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ROYAL COMMISSION OF INQUIRY INTO CERTAIN  
DEATHS AT THE HOSPITAL FOR SICK CHILDREN AND  
RELATED MATTERS.

Hearing held  
8th floor  
180 Dundas Street West  
Toronto, Ontario

The Honourable Mr. Justice S.G.M. Grange

P.S.A. Lamek, Q.C.

E.A. Cronk

Thomas Millar

*Rowe: X*  
*Stentley (Cont'd)*  
*Hunt*  
*Perceived*

Commissioner

Counsel

Associate Counsel

Administrator

Transcript of evidence  
for

August 24, 1983

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Hearing held on the 8th Floor,  
180 Dundas Street West, Toronto,  
Ontario, on Wednesday the 24th  
day of August, 1983.

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THE HONOURABLE MR. JUSTICE S.G.M. GRANGE - Commissioner  
THOMAS MILLAR - Administrator  
MURRAY R. ELLIOT - Registrar

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APPEARANCES:


P.S.A. LAMEK, Q.C.)	Commission Counsel
E. CRONK )	
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I.J. ROLAND)	Counsel for The Hospital
R. BATTY )	for Sick Children
M. THOMSON )	
B. PERCIVAL, Q.C.)	Counsel for The Metropolitan
D. YOUNG )	Toronto Police
W.N. ORTVED	Counsel for numerous Doctors at The Hospital for Sick Children
F. KITELY )	Counsel for the Registered
E. McINTYRE)	Nurses' Association of Ontario
E. SYMES )	and 35 Registered Nurses at The Hospital for Sick Children





APPEARANCES:

1		
2	M. COHEN	Counsel for the Ontario
3		Association for Registered
4	W.A. BOGART	Nursing Assistants
5		
6	G.R. STRATHY)	Counsel for Phyllis Trayner -
7	P. RAE )	Nurse
8	C. BUHR	Counsel for Sui Scott - Nurse
9	B. JACKMAN	Counsel for Mrs. M. Christie -
10		R.N.A.
11	J.A. OLAH	Counsel for Janet Brownless -
12		R.N.A.
13	M. MANNING, Q.C.)	Counsel for Mr. & Mrs. Gosselin,
14	S. LABOW )	Mr. & Mrs. Gionas, Mr. & Mrs.
15		Inwood, Mr. & Mrs. Turner, Mr.
16		& Mrs. Lutes and Mr. & Mrs.
17		Murphy (parents of deceased
18		children)
19	W.W. TOBIAS	Counsel for Mr. & Mrs. Hines,
20		(parents of deceased child
21		Jordan Hines)
22	F.J. SHANAHAN	Counsel for Mr. & Mrs. Dominic
23		Lombardo (parents of deceased
24		child Stephanie Lombardo); and
25		Heather Dawson (mother of
		deceased child Amber Dawson)
	J. SHINEHOFT	Acting for Lorie Pacsai and
		Kevin Garnet (parents of
		deceased child Kevin Pacsai)



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LN/ak

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---Upon commencing at 10:00 a.m.

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THE COMMISSIONER: I think the first thing I want to do this morning is to get the attention of counsel.

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7

Yes, Mr. Labow, you have a problem, have you?

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14

MR. LABOW: No, there is no problem. I just want to inform you, sir, that there is a possibility that Mr. Manning may be able to squeeze in due to offers of counsel, if he can get here on time, and he might be able to make himself available tomorrow. If Mr. Percival and Mr. Hunt have finished their cross-examination, he will go at that time. But if not, he will find another way.

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THE COMMISSIONER: Yes, all right. I was just going to speak about he order, the ordinary order. It is purely arbitrary the one I have chosen and I am quite happy to change it if anybody wants to, and of course it will be changed for particular witnesses. So that I do not think there is any point in people changing where they are seated.

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25

But the order that I have down here for cross-examination in the ordinary event is as follows: Nelles, Trayner, the Attorney-General, the





1  
2 Hospital, the Doctors, the Police, the Nurses, the  
3 Nurses' Assistants, Scott, Christie, Brownless,  
4 which is not the right name now, it is I believe Vereeken,  
5 and then the parents, and the order I have are those  
6 represented by Mr. Manning, Mr. Tobias, Mr. Shanahan  
7 and Mr. Shinehoft, in that order.

8 Now, there is no reason why you  
9 cannot make an arrangement to be different; there is  
10 no reason why I cannot change it as a general rule,  
11 and there is no question that I will change it as  
12 a particular rule when certain witnesses are being  
13 called. For instance, if Miss Nelles were called,  
14 obviously her counsel would go first and last,  
15 similarly with Mrs. Trayner, similarly with any of  
16 the other nurses and with the doctors and anyone else  
17 under those circumstances.

18 Has anybody any comments on that  
19 order pro or con? It is just so you will know where  
20 you stand, that is all.

21 MR. SHINEHOFT: Mr. Commissioner,  
22 is it going to be the usual arrangement where a person  
23 commences so-called cross-examination of his own witness  
24 when he does not introduce that person as a witness  
25 but as a Commission witness, that he will have a  
chance to examine or re-examine that person after the





1  
2 cross-examination of the witness has been completed?

3 THE COMMISSIONER: Yes, that is the  
4 rule. It is an individual rule. I don't know if  
5 it has been written down anywhere, but that is what  
6 I have been doing here and what I have done before.  
7 I think it is a fair thing.

8 Now, there may be a question some-  
9 time as to whether the Commission witness is really  
10 related to one particular counsel or not, but we have  
11 not run into that problem. Obviously, Dr. Rowe is  
12 related to the Hospital and to Mr. Ortved.

13 MR. SHINEHOFT: I just wanted to  
14 make sure, Mr. Commissioner, that it was not a rule  
15 applicable just for the evidence of Dr. Rowe because  
16 his evidence was being so critical to the hearing.

17 THE COMMISSIONER: No, it will be  
18 a rule with respect to every Metropolitan Policeman;  
19 it will apply to Mr. Percival and every Crown attorney  
20 and what have you, it will apply to the Attorney-  
21 General, but not necessarily every nurse, will it  
22 apply to the nurses because some of the nurses are  
23 separatately represented.

24 Now, the next thing I want to say  
25 is that the meeting of funded counsel is arranged for  
26 4:30 this afternoon in Hearing Room No. 2. It is of





1  
2 course a private meeting, only for funded counsel.

3 If that turns out to be a hopeless  
4 time, could you let me know at noon and we will try  
5 to change it.

6 Now, Mr. Strathy.

7 MR. SHINEHOFT: Mr. Commissioner,  
8 could you tell counsel where Hearing Room No. 2 is?

9 THE COMMISSIONER: I am sorry, it  
10 is on the 21st floor and it will be opened and  
11 available to us, I understand, at 4:30 this afternoon.

12 Yes, Mr. Roland?

13 MR. ROLAND: Mr. Commissioner, I  
14 have some toys for us this morning. They are  
15 introduced from the Hospital.

16 The first is a 60 millilitre syringe.  
17 I think all of these arise out of Mr. Strathy's  
18 examination yesterday.

19 THE COMMISSIONER: Millimetre, did  
20 you say?

21 MR. ROLAND: Millilitre.

22 DR. RICHARD DESMOND ROWE, Resumed

23 MR. ROLAND: Dr. Rowe, I am showing  
24 you this syringe. What is that used for?

25 THE WITNESS: I think this is used  
to mix up any solutions that are being given in large





1  
2 volume, perhaps like a large amount of bicarbonate  
3 or something like that.

4 MR. ROLAND: I think this is the  
5 largest syringe we could find in use in the Hospital.

6 THE COMMISSIONER: All right, that  
7 will be what number?

8 THE REGISTRAR: 145.

9 THE COMMISSIONER: 145.

10 ---EXHIBIT NO. 145: 60 millilitre syringe.

11 MR. ROLAND: Then I have a 6 milli-  
12 litre syringe, and on the case we have marked "All  
13 purpose use to give oral or injectable medications".  
14 Is that your understanding of the use of that syringe?

15 THE WITNESS: Yes, I believe so.

16 MR. ROLAND: And I take it when  
17 you are going to inject a medication with the use  
18 this syringe you place a needle on the end of it,  
19 would you?

20 THE WITNESS: Yes, you would.

21 MR. ROLAND: We do not have a  
22 needle for this one.

23 THE COMMISSIONER: When you say for  
24 all purposes, is that for all patients or particularly  
25 for babies or for children?





1

THE WITNESS: It would be for ---

2

3

THE COMMISSIONER: It is obviously --

4

because your Hospital is just for children, so I guess  
it is just for children?

5

6

THE WITNESS: Yes, just for children,

7

but it is a general purpose syringe where the  
quantity is over 1 millilitre and more than even 3.

8

9

THE COMMISSIONER: 146.

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---EXHIBIT NO. 146: 6 millilitre syringe.

11

MR. ROLAND: Next is a three

12

millilitre syringe and marked on the case is the

13

notation "Used to administer oral or injectable drugs,

14

small doses". Dr. Rowe, could you tell us what that

15

syringe would be used for?

16

THE WITNESS: Yes, that would be

17

used for the purpose as described. It would be

18

largely employed for any dose over 1 millilitre and  
under 3.

19

MR. ROLAND: And finally, a smaller

20

syringe marked on the case "TB syringe". What does

21

"TB" stand for?

22

THE WITNESS: Tuberculin syringe.

23

MR. ROLAND: 1 millilitre syringe,

24

small doses of drugs or oral digoxin -- oral or

25





1  
2 injected. Is that the sort of syringe that would be  
3 used for administering digoxin?

4 THE WITNESS: As long as the  
5 individual dose is under 1 millilitre, and this is  
6 commonly the syringe used for small babies, more  
7 particularly for the elixir as well.

8 MR. ROLAND: Yes. And I take it  
9 for the elixir, you would not place a needle over  
10 the end of the syringe?

11 THE WITNESS: No.

12 MR. ROLAND: And you would if you  
13 were injecting it?

14 THE WITNESS: Yes.

15 MR. ROLAND: Perhaps we could have  
16 the 3 millilitre as 147 and the 1 millilitre as 148.

17 THE COMMISSIONER: Yes, all right.

18 ---EXHIBIT NO. 147: 3 millilitre syringe.

19 ---EXHIBIT NO. 148: 1 millilitre syringe.

20 THE COMMISSIONER: All right,  
21 Mr. Strathy.

22 CROSS-EXAMINATION BY MR. STRATHY: (Continued)

23 Q. Doctor, is there any syringe  
24 in use in the Hospital that falls in the range between the  
25 60 millilitre and the 6 millilitre?





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A. Yes, I think there is a 30 and 20 amount syringe.

Q. But this 60 millilitre is the one you suggested would have to be used if one wanted to inject 20 of those 2 cc ampoules; is that right?

A. Well, something around that size anyway.

Q. But this syringe, as I understood it, would not be used in the normal therapeutic treatment in the Hospital, would it?

A. Not ordinarily. I think at least on the cardiac ward I understand that would only be used occasionally for solutions of large volume like bicarbonate might have to be extracted or something like that.

Q. And when would bicarbonate be used?

A. That would be used at the time of arrests.

Q. As we have seen on the charts, bicarbonate is one of the things that seems to be fairly commonly used at arrest?

A. Yes.

Q. Now, dealing with the 1 cc





1  
2 syringe, which was the last exhibit, do I understand  
3 that what is done by the nurses in administering  
4 digoxin is that they use that particular syringe,  
5 and in the usual course they fill it with the elixir  
6 or put some elixir into it and inject it directly  
7 into the child's mouth?

8 A. Yes, that is my understanding.

9 Q. And can you give us an indica-  
10 tion -- this is a 1 cc syringe -- how much would  
11 generally be used in a dose?

12 A. Well, it depends on the weight,  
13 but if you were giving a dose of .02 -- well, let us  
14 make it simple, .025 milligrams, that is 25 micrograms  
15 of the material, you would fill the syringe up to  
16 the mark that is half a millilitre. See, it is a  
17 tuberculin syringe. It has two scales, but the  
18 .1, .2, .3, .4, .5 is clearly alineated, and that  
19 is much more accurate than the dropper supplied by  
20 the bottle which is the reason why nurses use that.

21 Q. So the syringe goes up to  
22 1.0 cc, but you would fill it up in this case to  
23 .5 cc?

24 A. Yes.

25 Q. And that would give you how  
much of the medication?





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A. That should give you .025  
milligrams.

4

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Q. And what size baby would you  
use that for?

6

7

A. Well, that would be maybe a  
5 kilogram baby.

8

9

Q. In any event, the doctor's  
instructions to the nurse would specify the amount of  
digoxin to be administered to the particular child?

10

11

A. Oh yes.

12

13

Q. The doctor would do the weight  
calculation in prescribing the medication?

14

15

16

A. Yes.

17

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Q. Doctor, I wonder if we can  
briefly look again at the transcript of -- or sorry,  
the records of Allana Miller, which we were looking  
at just at the end of yesterday.

23

24

25

Just before we come to that, perhaps  
I can ask you something, Doctor, and it arises out  
of something you said at Volume 18 of the transcript  
where you were being examined by Mr. Lamek, and  
you were talking about explanations for some of the  
digoxin levels in some of the babies that gave you  
concern.

The reference is Volume 18 at page





1  
2 3236, and you were talking about giving some further  
3 thought to the whole question. This is page 3236  
4 at the top of the page, and I will read it to you,  
5 Doctor, from the transcript. You said:

6 "...I have had some other thoughts  
7 about that, but I think those are  
8 matters that have emerged a long time  
9 since over the question of what  
happens to digoxin --

10 MR. LAMEK: All right."

11 You continued:

12 " -- in tissue after death and when  
13 a patient has been resuscitated.

14 MR. LAMEK: Q. There may be some  
15 question as to what that level means?

16 A. Yes."

17 And then over at page 3240 at the middle of the page  
you said this:

18 "The question about the postmortem  
19 levels of digoxin in blood particularly  
20 I think probably applies here. I  
21 think that is the term rather than  
22 tissue, assuming that there was a  
23 blood sample of 78 nanograms per  
24 millilitre.  
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"I think I am aware now although I  
wasn't at the time, of course, that  
in somebody who has had a resuscitation  
effort where there is compression  
of the chest and where there may be  
electrical stimulation and where  
there may be even damage to the  
muscle might lead to the formation of  
an increased concentration of digoxin  
in the blood within the heart."

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"I don't pretend to say whether that is the case or in this particular instance, but being aware of that I have to modify a little bit what I originally felt."

And then the Commissioner said:

"Yes, all right. And you will have an opportunity at any rate, not immediately, to elaborate as much as you like on that."

I would like to give you that opportunity and ask you, if I may, Doctor, if you could elaborate and tell us, is it your view that some of the events that take place during resuscitation efforts may affect the level of digoxin in the patient's system?

A. Yes, I think that is so.

Q. And is one of the events the defibrillation or the shocking that takes place of the particular patient?

A. Well, I am lead to believe that is the case. I think I've said repeatedly that I'm not an expert in this area and the people that are most likely to provide the best input to that question are the clinical pharmacologists.

Q. Well, just to at least satisfy





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my curiosity, do you have an understanding as to how that defibrillation affects digoxin?

A. Not specifically. I have heard that mentioned and I am aware of that concern on the part of the pharmacologists.

Q. All right, that's one thing then in the arrest, the resuscitation effort. What about the process of massage or what I understand to be a vigorous massaging of the child's chest in the course of resuscitation?

A. Yes.

Q. Is that something that may affect the digoxin in the system?

A. I don't know for sure but I have heard that that is a situation; at least, those are the points that I meant in that testimony, that we have been talking for a long time about digoxin, as you can imagine, and I think that my understanding is that that can occur, but I do not have all of the evidence upon which I can produce firm statements.

Q. Well, perhaps the thing you can tell us about is what does happen at the arrest in terms of the massage, what takes place at that time?

A. Well, all I can tell you again





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is what I know from very long experience before but not in recent times that cardiopulmonary massage, resuscitation, implies massaging the heart by compression of the sternum against the spine and that is a vigorous movement in a heart that is not beating and there can be damage to the heart as a result of that and also as a result of defibrillation, use of electric currents and so on.

My understanding is that those things can bring about release of digoxin into the blood, that's all.

Q. This massage which you describe as your vigorous one I gather is a natural forcing of pressure against the sternum of the child?

A. Yes.

Q. Am I right that you have indicated that it may cause some damage? Am I right that in the early days at least there were instances of considerable damage to the heart and other organs, that type of thing?

A. Yes, and I think that one would expect that risk to be higher in the longer resuscitation proceedings.

Q. And as we have seen in some of these cases with 60 or 75 minute resuscitation efforts





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you might expect some sort of damage in any event?

A. Well, you might, yes.

Q. And you say again this  
defibrillation exercise may also cause tissue damage.  
Is that something you have observed?

A. No, but we do know that it  
may do that from experimental evidence.

Q. Now, a third thing that takes  
place at the time of cardiac arrest as I understand it  
is the injection of a number of drugs, as we have  
seen in the records, including some drugs injected  
intracardiac. Do you have any information as to  
whether that may affect the digoxin levels in the  
heart or in the blood?

A. No, I'm not sure of the answer  
to that.

Q. Have you heard that suggested?

A. I think that if you give  
potassium and there are a number of other substances  
that can be injected, all of which, of course, are  
potentially dangerous materials --you can get damage  
to the heart from injection of catecholamines --  
adrenaline or epinephrine. If given in very large  
doses it causes actual necrosis of myocardial cells.

Q. That is dying of the cells?





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A. Yes.

Q. Yes.

A. If it is given in very large doses. But I'm not any more aware of it than that. I think again the persons whom are most experienced with the resuscitative effort, the people that are involved with the resuscitation committee are the people that are likely to be able to answer that sort of question in more detail than I can.

Q. I'm sorry, you said the resuscitation committee?

A. Yes.

Q. Is there such a committee within the hospital?

A. Yes, there is a resuscitation committee in the hospital which is headed by an intensivist.

Q. And I gather from what you said earlier, yesterday, that there was some type of manual for Code 25s as well?

A. Yes, there is a manual that is issued to the resident staff and to the people who are involved in resuscitation teams because that process is one which is governed by the resuscitation committee of the hospital. It is not a ward activity directly,





B6

1  
2 it is a special team, flying squad.

3 Q. All right. Well, Doctor, I will  
4 defer my other questions on the Code 25 until we hear  
5 from some of those witnesses. But while you have  
6 Allana Miller's chart, would you turn please to page  
7 52, which is the final autopsy report. At the bottom  
8 of page 52, item no. 5, I wanted to ask you about that  
9 because it refers to resuscitation associated trauma  
10 with (a) left hemothorax; (b) right hemothorax and  
11 (c) hemopericardium. I take it that that is injury  
12 to the child as a result of the cardiopulmonary  
13 massage?

13 A. Yes.

14 Q. And the hemothorax, what is  
15 that?

16 A. That means the blood in the  
17 right chest cavity.

18 Q. And what about the hemoperi-  
19 cardium?

20 A. That means blood in the  
21 pericardial cavity. That's the cavity between the  
22 pericardium, which is the sling in which the heart sits,  
23 and the heart itself.

24 Q. And where does that blood in  
25 (a), (b) and (c) come from, do you know?





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A. It must come from the heart.

Q. Is that blood literally squeezed out of the heart as a result of the pressure that is applied?

A. There must have been some injury to either the ventricle or the artrium and a fracture of the wall.

Q. I see. So, in effect, it is really bleeding then, it is not squeezing.

A. No, it is bleeding.

Q. All right, thank you.

Doctor, incidentally, one of the things that you mentioned I think in your evidence with Mr. Lamek was that you would look for the <sup>one</sup> Q cards that were going to be or had been put at some point on the resuscitation carts. I know you have had more things to think about than that, but have you had an opportunity to look for those?

A. I have indeed.

Q. Have you had any success?

A. I have had no success and I can explain why I have had no success.

Q. Well, this might be as good a time as any.

A. When I went to the floor to





B8

1  
2  
3 pick up what I thought were the large print cards that  
4 we had made, they weren't in evidence. There was  
5 instead a laminated card of about legal stationery  
6 size which contained the doses of all the drugs,  
7 appropriately measured so that people could easily  
8 calculate the dose if they needed to check anything.  
9 But it was very small print, not the sort of thing  
10 that I would imagine that I had put together.

11  
12 So then, that made me think that  
13 maybe I was really losing my mind after all, but I  
14 went to the visual education department and checked  
15 with them and we tried to work out the approximate  
16 time when they might have done the work order for that  
17 work and they couldn't find a definite record because  
18 things aren't put down in that sort of specific way.

19  
20 Unfortunately, of course, there has  
21 been such a big turnover of nurses on the floor that  
22 there are not too many people around who remembered  
23 this card. One nurse did that I spoke to. And then  
24 we asked the pharmacy who obviously had replaced the  
25 card with a new transhospital system with a laminated  
card whether they had seen it and the only person that  
I could find who remembers it is the clinical  
pharmacist who was one the ward at that time.

She had a look for it in the pharmacy





B9

1  
2 and the nurses on the floor had a look for it in their  
3 offices and nobody can find it. So, it presumably has  
4 been thrown out. I wasn't very pleased about that but  
5 that was what happened.

6 Q. In any event, there was, for  
7 at least a time, on these crash-carts a large card  
8 with the dosages and so forth on it?

9 A. I think until the time that  
10 the hospital changed the system of the drug portion of  
11 the emergency cart.

12 Q. I see, there was some change in  
13 the carts themselves, was there?

14 A. There was a change taken after  
15 March, and I'm not sure when after March that was but  
16 there was a change made in the way in which the drugs  
17 on the cart were contained. They had formerly been  
18 put into position, as I understand it, by the head  
19 nurses according to the recommendations of the  
20 resuscitation committee, but with some modifications  
21 according to what doctors and nurses felt might be  
22 needed on a particular ward.

23 Now the drugs that are used in  
24 resuscitation come in a red box that contains the  
25 specific drugs that are being decided by the  
resuscitation committee and presumably pharmacy and





1  
2 that is under the control of pharmacy.

3 Q. Well then, pre-March '81, the  
4 drugs that were on the carts in 4A and 4B were  
5 actually loaded on the carts or stacked on the carts  
6 by the nursing staff in the ward, is that correct?

7 A. That is my understanding. Now,  
8 that is a nursing responsibility and I have not had  
9 anything to do with that directly.

10 Q. All right.

11 A. But I understand that is the  
12 case.

13 Q. Doctor, do you have any  
14 understanding as to whether in 4A and 4B at that time,  
15 March '81, digoxin was one of the drugs that was  
16 supposed to be on the crash-carts?

17 A. I don't know whether it was or  
18 not, but I wouldn't see any particular reason for it  
19 to be on the crash-cart.

20 Q. Well, I want to ask you in that  
21 connection a question about something that appears in  
22 the statement of prima facie facts, page 92. You  
23 won't have that document I don't think.  
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I will start over on page 91, and it refers to:

"Also during the evening of March 21, 1981, the Chief of Paediatrics at the Hospital issued instructions which provided, inter alia:"

And then there is (a) through (e):

"(a) All digitalis will become a control drug immediately and treated as a narcotic.

"(b) All digitalis will be dispensed by either team leaders or charge nurse ... etc.

"(c) Doctors. Costigan and Mountstephen will do a check of all crash-carts for parenteral digitalis preparation;

"(e) All crash-carts will be checked daily for the parenteral digitalis."

Now, as I understand it parenteral is a reference to the ampules, is that right?

A. Yes, that is the only ...

Q. And this would appear at least to reflect some concern on the part of Dr. Carver, the Chief of Paediatrics, that there was digitalis on the crash-carts?





C.2

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2 A. I think it has been found on  
3 crash-carts, yes. I am not sure whether it was found  
4 on that particular ward.

5 Q. But it seems to suggest perhaps  
6 concern that digitalis may have found its way onto  
7 the crash-carts in 4A and 4B?

8 A. Or anywhere in the Hospital, I  
9 think. There might be reasons, you know, there are some  
10 theoretic reasons why you might have digoxin on the  
11 crash-carts, because with somebody who has say, a  
12 supraventricular tachycardiar which is a very, very  
13 rapid rate of 250 or more in the top chambers of the  
14 heart, digoxin would be part of the therapy. Generally  
15 speaking I think our position would be that if you  
16 have a baby sick enough to need a crash-cart for  
17 supraventricular tachycardia you would not, the first  
18 drug you would be using would not be digoxin, you  
19 would be using that subsequently.

20 Q. So would it be fair to say you  
21 would not usually expect digoxin to be one of the  
22 medications on 4A and 4B crash-carts?

23 A. Yes.

24 Q. Just one last question on the  
25 subject of crash-carts, or cardiac arrests before I  
(2) 23 move to the last child, and that is this. You





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mentioned at some point in your evidence, again while being examined by Mr. Lamek, that your success rate, if I may call it that, from cardiac arrests was around 11 per cent, do you recall that?

A. That was - yes, I do recall saying that.

Q. Was that the 11 per cent of the babies who had cardiac arrest were able to be resuscitated?

A. Yes, that was information that was available from the CDC report.

Q. That is the Atlanta Report?

A. The Atlanta Report, and it applied to the period between July, or June 30th I think perhaps and the period of March, late March.

Q. I had understood, Doctor, that it was suggested, it was suggested by you that that 11 per cent rate was consistent either with the Hospital's previous experience, or with generally found experience in this type of patient?

A. Well, I think in general that is what I implied and said. The success rate is much lower than most people think.

Q. I was going to say that, from television we seem to think it happens inevitably that the patient is resuscitated.





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A. Yes. The figures that are available in the world of the adult are somewhere in the range of 10 per cent to 15 per cent. You know some hospitals vie with others to produce a figure that is near 19 per cent or 20 per cent. There have been reports in the Canadian medical literature of success rates as high as 19 per cent, which everybody regarded as extremely good.

Q. That is in adults, is it?

A. In adults.

Q. Yes.

A. There is not so much data on this available in children. I think we are lacking a little bit in solid substantial numbers of cases reported in this regard, and we don't have much information about cardiac wards. That information should be available, and is really part of the thing that the Resuscitation Committee tries to do, but they have had considerable difficulty in getting completeness of the records.

Q. May I take it then that the figure of 11 per cent in children on these wards in that particular period is not a particular surprise to you?

A. No.





C.5

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Q It is about what you would expect?

3

A I would have thought so.

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Q The last child then is Justin Cook,

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who was the last child in the period to die. Again,  
6 Doctor, you have referred to this child as a high risk  
7 patient. Dr. Jedeikin in his note on page 25 of the  
8 record calls for strict supervision of the child. The  
9 child was scheduled for immediate emergency surgery  
10 and I take it once again you were not particularly  
11 surprised by the death of this child. What does give  
12 you concern is the antemortem and postmortem digoxin  
13 levels in a child who was not supposed to be receiving  
14 digoxin, is that right?

13

A Yes, that's right.

14

Q Now Doctor, the fact that Justin  
15 Cook was not receiving digoxin I would think would be  
16 apparent to any doctor or nurse who read the chart,  
17 would that not be so?

18

A Yes.

19

Q The nursing staff certainly in  
20 the ward would, I would think, know which patients  
21 are and are not receiving digoxin?

21

A Yes.

22

Q And in addition, certainly by the  
23 time Justin Cook died, it would have been well known  
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in the ward that there was a great to-do going on about digoxin, because digoxin had been made a controlled substance as we know on the 21st of March?

A. Yes.

Q. People had come around and picked up the supplies, cleared the supplies out of the medication rooms, put in new supplies and required that it be treated in effect as a narcotic.

THE COMMISSIONER: You realize of course he came on the 20th of March.

MR. STRATHY: Well, I think I was careful to say by the time the child died.

THE COMMISSIONER: I am sorry.

MR. STRATHY: Q. Maybe I should have been more precise about that. He died on the 22nd, and as we know by the evening of the 21st digoxin had been made a controlled substance.

I just wanted to ask you one thing about Justin Cook and it arises out of some evidence given at the Preliminary Inquiry by a Dr. Kantak. Dr. Kantak was one of the residents on the ward?

A. He was, General Paediatric Resident.

Q. And it appears that Dr. Kantak was present and observing the child at various times in the evening that he died.





C.7

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3 Let me just read to you a portion of  
4 Dr. Kantak's evidence, it comes from Volume 25, sub 2,  
5 page 25 of the Preliminary Inquiry:

6 "Q. In any event you went to bed and  
7 I understand in the early hours of the  
8 morning you were called, Dr. Kantak?

9 "A. Yes, around 2-3 o'clock I was  
10 called and the nurse informed me that  
11 the baby was blue and was in bad shape.

12 "Q. Which nurse was that, do you know?

13 "A. They called me, I don't know.

14 "Q. You were on the floor, on the  
15 4th floor?

16 "A. Yes, sir, I walked off from the  
17 room up to the ward and saw the baby.  
18 The baby indeed had turned very ill. I  
19 examined the baby and he did not have  
20 any murmur. I realized the baby had a  
21 tet., t-e-t, so I gave the baby intra-  
22 venous propanolol. I don't know what  
23 the exact amount but it would be some-  
24 where around .1 to .2 milligrams per  
25 kilo of the dose."

Let me just stop there, what is a tet. that is t-e-t,  
is referred to on the chart, page 25, as well?





C.8

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A. That is an episode of increased lack of oxygen in a baby who already is suffering from some oxygen lack.

5

Q. Is it - I am sorry ---

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A. And it refers, it is an abbreviation for the word "tetralogy of Fallot" because the malformation of the heart which most characteristically produces that set of symptoms, a sudden increase in oxygen lack and difficulty with breathing, heavy breathing and unconsciousness is the tetralogy of Fallot, that is the malformation that usually is associated with that spell, but it can occur in any other cyanotic malformation with reduction in blood flow to the lungs.

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Q. Thank you. Then just carrying on, he says:

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"A. So I gave him intravenously that medication propranolol, intravenous propranolol, which I took from the foot end of the bed again. There was a vial of inderal, of propranolol attached to the syringe.

22

"Q. Had you drawn that up earlier?

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"A. No, I didn't draw it, it was drawn earlier because the order





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"suggested it should be drawn and attached to the foot end of the bed.

"Q Did you see it being drawn up?

"A. No, sir.

"Q But it was drawn up and attached to the bed earlier?

"A. Yes, sir.

"Q. How much was in the syringe, do you recall?

"A. I had ordered for 1 millilitre of propranolol to be drawn but I do not remember how much was in the syringe."

And Doctor, if you look at page 13 of the record, there is at the very bottom of the page, do you have that?

A. Yes, I do.

Q. There is a doctor's order apparently signed by Dr. Kantak, who says:

"Keep 1 millilitre (1 microgram) of propranolol by bedside."

And reading that order in conjunction with the evidence I have just read to you, suggests that Dr. Kantak ordered that propranolol be drawn up and attached in some way, or taped in some way to the end of the bed.





C.10

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2 All I want to ask you, Doctor, is that  
3 an appropriate practice for the Hospital to do that  
4 sort of thing?

5 A. Well, I would think that is not  
6 a usual practice, but I think in the circumstances it  
7 was good medicine.

8 Q Can you tell us why, please?

9 A. Well he had, I think he had  
10 given - he had given one lot of propanolol at the time  
11 of the first episode and had dramatic effect. I  
12 presume that he felt that if that was likely to happen  
13 again it would be useful to have the material ready  
14 and not to have to pull it up from the syringe and so  
15 on. I think it is sort of an anticipation of a  
16 problem. Although there are some obvious problems  
17 about keeping medication sort of floating as it were,  
18 I think that was a reasonable suggestion.

19 Q I take it it indicates a  
20 sufficient concern on Dr. Kantak's part about the  
21 state of the baby, that he felt that it would be  
22 necessary to have the medication right at hand as it  
23 were?

24 A. Yes.

25 Q And just what is it, if you can  
tell us briefly what propanolol does?





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A. Well, propranolol has an effect that is not certain, the effect is not absolutely explained in the spells, but it is believed that it affects the heart muscle by reducing the force of contraction, and that it may have other effects on the peripheral circulation which are less clearly understood that may benefit the patient, and therefore break the spell.





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MR. STRATHY: Thank you, Mr. Commissioner,  
those are all my questions.

THE COMMISSIONER: Thank you, Mr.  
Strathy.

Mr. Bogart?

MR. BOGART: Sir, we have no questions  
of this witness.

THE COMMISSIONER: All right, thank  
you. Now, where is ---

MR. BOGART: I will go and get Mr.  
Hunt. He is just outside.

MR. PERCIVAL: I believe matters moved  
a little quicker and more unexpected than we all  
thought, Mr. Commissioner.

THE COMMISSIONER: I do not find that  
distressing.

MR. PERCIVAL: I would not have thought  
you would.

THE COMMISSIONER: You cannot trust  
anybody around here, Mr. Hunt.

MR. HUNT: I beg your pardon, Mr.  
Commissioner?

THE COMMISSIONER: You cannot trust  
anybody around here.

MR. HUNT: No, I thought I was going





1  
2 to have a nice leisurely hour and a half outside.

3 MR. STRATHY: I can continue for a  
4 little while.

5 MR. HUNT: I have some handouts. I  
6 did not want to be left out of the handouts so it  
7 is going to take me a moment just to sort those out.

8 THE COMMISSIONER: Yes, all right.  
9 Do you want these made exhibits or not?

10 MR. HUNT: Well, in actual fact,  
11 Mr. Commissioner, the documents that I have just  
12 handed out are photocopies from the Chart for Laura  
13 Woodcock, which is already in, and this is just for  
14 ease of reference for everybody's benefit.

15 The other document, which is a photo-  
16 copy of Section 10 of the Coroner's Act, I think can  
17 be found by anybody in the Statutes, so I do not  
18 propose to mark them, but if anybody wishes, we can.

19 THE COMMISSIONER: Yes, all right.

20 CROSS-EXAMINATION BY MR. HUNT:

21 Q. Now, Dr. Rowe, I would like  
22 to ask you firstly whether you have a general  
23 familiarity with certain provisions of the Coroner's  
24 Act?

25 A. Yes, I do.

Q. And in particular, I take it





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you would be aware in the normal course of your day to day activities of the provisions of what is now Section 10, but I think what we will see on some of the charts was referred to as Section 9 of the Act, which deals with reporting cases to the coroner?

A. Yes.

Q. Now, do you have a view as to the purpose that the Office of the Coroner serves?

A. Yes, I think so.

Q. And as far as you are concerned, what purpose does he serve?

A. I would, at least from our point of view, assume that he serves as the medical ombudsman, if you like, in regard to death.

Q. In fact, the Act itself sets up really a complete structure within which he operates as in effect a watch dog or a public watch dog as well over the question of death, does he not?

A. Yes.

Q. Would you agree that it seems reasonable that inasmuch as the issue of death is something that concerns -- is going to ultimately concern all of us and is something in which the public at large has a great interest, that the coroner, in fulfilling those requirements on him set out in the Coroner's Act is really discharging





1  
2 an important public duty?

3 A. Oh yes.

4 Q. Now, Section 10 of the  
5 Coroner's Act in the Revised Statutes of Ontario,  
6 1980 has been distributed, and I think I can safely  
7 say, Mr. Commissioner, that it is identical to what  
8 was Section 9 of the Coroner's Act, 1972 in the  
9 Statutes of Ontario 1972, and that becomes relevant  
10 because in some of the documents that we are going  
11 to look at here from the Woodcock file there will  
12 be reference to Section 9 on the face of the  
13 document.

14 With respect to Laura Woodcock, and  
15 there is no real significance to the fact that these  
16 documents were taken out of that file, it is merely  
17 that they demonstrated the points that I wish to  
18 ask you about, perhaps we could begin by just  
19 identifying them. They are pages 23 to 26 of Laura  
20 Woodcock's file, and Dr. Rowe, it appears there are  
21 two check lists here. Each of them is entitled  
22 "The Hospital for Sick Children, Death Check List"  
23 but they appear to be different, suggesting that  
24 perhaps they come from different sources. They are  
25 different not only in terms of their format but if  
you turn to page 26, which is the last of the four





5 1  
2 pages that you have, you will see that there the  
3 Coroner's Act, 1972 is set out, and particularly,  
4 Section 9, and on the second page of the first check  
5 list, which is page 24, you will see that rather  
6 than setting out Section 9 of the Coroner's Act,  
7 the Hospital sets out under the heading "Coroner's  
8 Cases" a number of instructions with respect to  
reporting.

9 But you will agree with me at this  
10 point, and we will deal with those later, but you  
11 will agree with me at this point that the two  
12 documents appear to be different?

13 A. Yes.

14 Q. And am I right that that  
15 suggests that perhaps they are different sources  
16 or do you have any other explanation for the difference?

17 A. I am not familiar with that at  
all. I do not have any explanation.

18 Q. All right. Before we deal  
19 with the documents, I would like to look at Section  
20 9 as it appears on page 26 that was handed out.  
21 The first significant aspect of Section 9 would  
22 appear to be found in Section 9(1) which requires  
23 every person who has reason to believe that a deceased  
24 person died in certain circumstances has a duty.  
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Now, Doctor, would you agree with me that that direction means that every person who is involved or becomes aware of the death of a person has that duty imposed on them, whether or not they are acting separately as a doctor or with a team of other doctors and nurses?

A. Yes, if there was reason to believe that there was a case worth reporting.

Q. Correct. In other words, there is no suggestion in the Act that the duty to report comes from a hospital or a particular team, but it is a duty imposed on every person?

A. Yes, I think so.

Q. Now, if we could just go on and look at the types of conditions that are set out in Section 9. Subsection (1)(a) sets out five: violence, misadventure, negligence, misconduct or malpractice. Those, I would suggest, are deaths that we could categorize as deaths arising from other than natural causes. It is a very broad categorization of them, but all of those would fall within that?

A. Yes.

Q. And (b) sets out separately death by unfair means, and I am not sure what that means, but that would be a death also involving an





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unnatural cause?

A. I presume so. I do not know what it means either.

Q. I do not think that one is particularly relevant for anything we are going to discuss here.

(c) involves deaths relating to pregnancy in any circumstances that might reasonably be attributable to the pregnancy; (d), suddenly and unexpectedly, and we have had discussion about that prior to today and we will have some more shortly, but again, that is a broad phrase which may include deaths from both natural or unnatural causes?

A. Yes.

Q. (e) is disease or sickness that was not treated by a qualified medical practitioner; (f) a cause other than disease; (g) any circumstances that require investigation.

Now, two points, I suggest, emerge from that. Number one, that these conditions that are set out are for the most part set out in very broad terms?

A. Yes.

Q. Perhaps the only real specific





1  
2 one is (c) involving pregnancy, but even that puts  
3 the requirement on a person where it is any circum-  
4 stance that might reasonably be related to the  
5 pregnancy?

6 A. Yes.

7 Q. So, would it be fair to  
8 categorize the conditions set out in Section 9,  
9 in addition to being broad, as those conditions that  
10 involve some unusual aspect?

11 A. Yes.

12 Q. Now, the other significant  
13 feature of Section 9, I suggest, comes in the closing  
14 words of Section 9 (1) where it describes the time  
15 at which the duty to notify takes place, and it  
16 refers to the person who has notice of death in  
17 appropriate circumstances must immediately notify the  
18 coroner.

19 A. Yes.

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Q. And that I suggest is in keeping with the rest of the Act, which puts on to the coroner the duty to take charge of the body and to conduct an investigation.

A. Yes.

Q. So, would you agree it makes sense that one's duty to report in an appropriate situation must be carried out immediately?

A. Yes.

Q. Now, one thing that the coroner may do at any stage of a coroner's investigation, you will agree with me, is to order a postmortem examination?

A. He may do.

Q. And that is authority that is given to him by the Coroner's Act.

A. I understand so.

Q. I suggest to you, sir, that by virtue of the provisions of the Coroner's Act that we have looked at and discussed and the underlying reason for it that we have discussed where a death takes place in usual circumstances so that it becomes reportable, there is a requirement that it be handled very carefully and the way in which it is to be handled is regulated very carefully by virtue





of this Act.

A. Yes.

Q. Do you agree with that?

A. Yes.

Q. Now, the hospital I suggest has recognized the realities of the duties imposed in the conditions where they arise by virtue of the inclusion of that information on the Hospital for Sick Children death lists as we see them in pages 23 to 26 of Laura Woodcock's file.

A. Yes.

Q. Whereas on the one death check list merely Section 9(1) is repeated, on the other one there is a heading which is Coroner's cases, under which there is a list of conditions which we will compare to the Coroner's Act in a moment, but which you will agree with me appear to be worded more as directions to Hospital staff.

A. Yes.

Q. In fact, it starts off saying that:

"The physician in charge of the case either personally or through the resident shall notify the Coroner's Office immediately and apprise the Executive Director..."





1  
2 I take it that is the Executive Director of the  
3 Hospital?

4 A. Yes.

5 Q. "...under the following  
6 circumstances".

7 And then it sets out circumstances (a) to (g).

8 Now, without going through them and  
9 comparing them word for word, would you agree with  
10 me that down to what we see under the heading  
11 Coroner's Cases as paragraphs (f) and (g), that is  
12 in paragraphs (a), (b), (c) and (d), the directions  
13 to the Hospital staff from the Hospital really follow  
14 the wording of the Coroner's Act. Would you agree  
with that?

15 A. Yes, I think so.

16 Q. As a matter of fact, I think  
17 the only differences are the reference to the Hospital  
18 in paragraph (d) and a patient whose death is known  
19 or suspected in paragraph (a), which is, the suspected  
part is not found in the Coroner's Act.

20 Now, sir, paragraphs (f) and (g) do  
21 not appear in the Coroner's Act in any form close  
22 to what they are on page 24, but direction (f) is  
23 that the case shall be reported to the Coroner's  
24 Office whenever there is any doubt about the  
25





1  
2 necessity of notifying the Coroner's Office, and (g)  
3 puts the same requirements on the physician in charge,  
4 or the resident, where doubt exists as to the cause  
5 of death.

6 Now, would I be correct in inferring  
7 that the Hospital in imposing those conditions is  
8 really saying that in light of the position of the  
9 coroner and in light of the reporting requirements  
10 of the Coroner's Act, where there is any doubt about  
11 reporting a case, that doubt is resolved in favour  
12 of reporting it.

13 A. Yes.

14 Q. And the only reference in  
15 the Coroner's Act to any condition that would appear  
16 to relate to those two conditions imposed by the  
17 Hospital would be paragraph 9.1(g) which puts the  
18 requirement to report on a person who has knowledge  
19 of a death under such circumstances as may require  
20 investigation. Would the Hospital's position with  
21 respect to doubt then be a reflection of the fact  
22 that in those cases further investigation may be  
23 required and, therefore, the Coroner ought to be  
24 notified?

25 A. Yes, I read it that way.

Q. Now, inasmuch as we have seen





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2 and we have discussed the fact that the coroner,  
3 as one of the steps that he can take in the course  
4 of investigation, may order postmortem examination,  
5 would you agree that the set-up insofar as the  
6 handling of unusual deaths is concerned is to turn  
7 over the investigation to the coroner immediately  
8 and to let him make the decision with respect to the  
9 ordering of a postmortem examination.

10 A. Yes. That would seem to be  
11 the logical way to go. I'm not sure it always goes  
12 that way.

13 Q. No. Well, we will look at  
14 some of the cases in a moment, but that is not to  
15 say that if a case at the time of death is not a  
16 reportable case that the Hospital couldn't do a  
17 postmortem examination with consent?

18 A. Yes.

19 Q. But where the case at the  
20 time of death is a reportable case, for one reason  
21 or another, then the question of postmortem examina-  
22 tion is one that falls within the Coroner's juris-  
23 diction?

24 A. Yes.

25 Q. Now, in terms of discharging  
the duty to report the case to the coroner, the





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practicalities of it as I understand them from the evidence to date involve really a phone call from one of the physicians, probably one who was present at the time of death or was brought in shortly thereafter and the case is simply related to the coroner over the phone?

A. That is the usual way as I understand it.

Q. And at that time certain basic facts concerning the patient's condition and death I take it are given to the coroner?

A. Yes.

Q. And based on those facts with respect to the condition and the death, the coroner may make a decision as to whether or not it is a reportable case, a coroner's case that he will take on and conduct an investigation.

A. Or he may not.

Q. He may or he may not.

A. Yes.

Q. Depending on the facts that are given to him at that particular time?

A. Yes.

Q. So, in any event, the practicalities of reporting a case to the coroner





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appear really to be quite simple: it involves a  
phone call.

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A. Yes, it involves a phone call;  
it may take a while to get the coroner, but it  
involves a phone call.

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Q. Once the coroner is on the  
phone it is just a simple matter of relating certain  
facts to him?

9

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A. Yes.

11

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Q. Now, if the coroner accepts  
the case then, as we have discussed, he takes over  
the investigation?

13

14

A. Yes.

15

Q. And he appoints a pathologist  
to do the post mortem if he chooses to order one?

16

17

A. Yes

18

Q. And he conducts the investiga-  
tion into the charts and into the results of any  
postmortem examination.

19

20

A. I understand so.

21

22

Q. So, am I correct that from  
the point of view of the Hospital, the actual  
involvement is limited to simply providing whatever  
information the coroner chooses to ask?

23

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A. Yes.

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Q. It doesn't involve at that point the Hospital doing anything on its own?

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A. No, not that I'm aware of.

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Q. And as a sort of a general summary of the practicalities of it, is it fair to say that really the reporting of a case to the coroner involves very little inconvenience to the procedure of the Hospital?

10

A. No.

11

Q. That's not fair?

12

A. No, I'm sorry, that is fair, yes, it does involve no inconvenience really.

13

14

15

16

17

Q. And in terms of the responsibilities that the doctors at the Hospital owe to a patient, would you agree with me that reporting that patient's death to the coroner is perhaps the least onerous of all the responsibilities?

18

A. Yes.

19

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23

Q. Now, I would like to look just briefly at the expression in Section 9.1, Subsection (d) "suddenly and unexpectedly". Now, you have indicated to us that there may be different definitions of those two words "sudden" and "unexpected" applied by different people?

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A. Yes.

25





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Q. And for different purposes?

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A. Yes.

4

Q. But would you agree with me

5

that essentially the concept of "sudden and unexpected  
6 death" is not really a very difficult one?

6

7

A. Oh, I don't agree with you,  
7 I think it is difficult.

8

9

Q. Well, would you agree with  
9 me that it only has any relevance in terms of  
10 cause of death and reporting the case to the coroner?

10

11

A. I think this is the gray  
11 area of the problem that we have with the Coroner's  
12 Act.

12

13

14

Q. I'm not disagreeing with  
14 your categorization of it as a gray area, I'm just  
15 saying that the concept of "sudden and unexpected"  
16 is one that arises in connection with death.

16

17

A. Yes.

18

Q. And its only significance  
18 insofar as death is concerned is, as I can see, with  
19 respect to - it raises questions of cause of death  
20 and it raises the question of reporting to the  
21 coroner.

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A. It may not cause any concerns  
23 about the cause of death.

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Q. It may or it may not.

A. It may not.

Q. Depending on the case?

A. It may not.

Q. But the one thing we know for sure is it raises a concern about reporting the case to the coroner.

A. Depending upon how you interpret the unexpected.

Q. Well, if we look at the Coroner's Act we see that it is not defined.

A. No, I understand that.

Q. And therefore it is one of those phrases that any reasonable definition of sudden and unexpected is going to fill the bill so to speak.

A. You can interpret it that way.





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Q. Isn't that the way you would interpret the duty under Section 9 to report "sudden and unexpected"?

A. I think we all have trouble with that "unexpected" question. That is, you know, I agree with you that what it says in the Act is what it says in the Act, but the interpretation of the "unexpected" portion seems to me to be a big handicap.

Q. But as long as someone is using a reasonable definition of "suddenly" and "unexpected", whatever it is, then in terms of discharging their duty under the Coroners Act they have done it?

A. Yes.

Q. And on the hospital's own interpretation of when they report a case, if there is any doubt about that, then you report the case?

A. Yes, that is what you would expect them to do.

Q. And that resolves any issues or duties to report?

A. I think so.

Q. Now, you have characterized yourself the terminal events of a great number of babies in question here as "sudden", without question,





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and yet in your view not unexpected?

3

A. Yes.

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Q. Now, you correct me if I am wrong, I don't want to be unfair, but I gather that the reason for your doing that involves your definition of "unexpected"?

6

7

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A. Yes.

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Q. And I take from what you told us with respect to the various babies, that you do not consider a death to be unexpected if the anatomic abnormalities of that baby make it likely that the baby is going to die at some point in time, not necessarily at any particular time, but at some point?

14

15

A. Yes. The difficulty that has arisen there is the temporal aspect of it.

16

17

Q. If, in your view, and I'm not being critical, I want you to understand that...

18

19

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21

22

A. Yes.

Q. If, in your view, the anatomic abnormalities are of such a nature, or so severe that it makes it likely that that baby is going to die, then when that baby dies that is not viewed as an unexpected death?

23

24

25

A. That is the position we have taken in many cases.





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3 Q. Would you agree with me that  
4 not every cardiologist on your staff would necessarily  
5 agree with the categorization of "unexpected" in every  
6 case?

7 A. That would be true.

8 Q. And in fact, we have seen  
9 several cases here, and we will look at some in a  
10 moment where it would appear that there has been  
11 reference to the death being unexpected by a cardiologist, where you yourself wouldn't classify it as  
12 unexpected?

13 A. Yes, but we haven't heard the  
14 other cardiologists' evidence yet.

15 Q. No question about that. There  
16 are cases where it appear, just from what we have on  
17 the record right now, that there have been some  
18 differences of opinion?

19 A. I am not quite sure that I  
20 would agree that there are differences of a major  
21 degree of opinion at all. I agree it is written down  
22 on the chart that they are sudden and unexpected.

23 Q. Certainly something that at  
24 this point in time we have some doubt about as to  
25 whether or not --

A. You probably have doubt, I am





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2  
3 not sure I have any doubt because I think that by and  
4 large the physicians agreed.

5 Q. All right, we will look at some  
6 of those cases.

7 MR. ORTVED: Well, let him finish.

8 Q. I'm sorry, sir, are you  
9 finished?

10 A. Yes.

11 Q. Would you agree with me, sir,  
12 that the effect of your categorization of "unexpected"  
13 has, or is the effect of your categorization of it is,  
14 that it brings within that concept the fewest number  
15 of cases?

16 A. Yes, in terms of death generally.

17 Q. In terms of whether or not  
18 death is expected?

19 A. Yes.

20 Q. It brings within your concept,  
21 your definition, brings within it the fewest number  
22 of cases?

23 A. The fewest number of cases of  
24 what base are you talking about?

25 Q. Of unexpected deaths?

A. It would bring out the fewest  
number that I would call unexpected.





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Q. Yes.

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A. Yes.

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Q. And your definition is going to bring, is going to exclude from the unexpected category a great number of deaths that another definition might bring within it?

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A. Yes.

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Q. And by defining it in terms of virtually inevitability of death as a result of anatomic abnormality, you really exclude the patients for whom the prognosis may be inevitable death but who go from a period of stability into cardiac arrest, or from a period of some improvement into cardiac arrest?

15

16

A. That would not be the case for most of them, but it could be for some.

17

18

19

Q. Well, I'm just saying to you that generally your definition of "unexpected" will exclude from that classification those types of deaths?

20

A. Yes, it may.

21

22

23

Q. Would you agree with me that the definition of "unexpected" involves the unlikelihood of death at a particular point in time would also be a reasonable definition?

24

A. Could I have that again?

25





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3 Q. Would you agree that the  
4 definition of "unexpected" would to the effect that  
5 death is unlikely at a particular point in time,  
6 would also be a reasonable definition?

7 A. Yes.

8 Q. And certainly for the purposes  
9 of reporting to the coroner that type of definition  
10 couldn't be considered unreasonable?

11 A. No.

12 Q. And that definition of  
13 "unexpected" would bring within that classification the  
14 death of a patient where the prognosis may have been  
15 for inevitable death, but where the death occurred  
16 at a point in time in the hospital of that patient  
17 where it was not regarded as likely?

18 A. It could.

19 Q. Now, if the definition that I  
20 have suggested was used, I suppose one effect would  
21 be there would be more reportable cases to the  
22 coroner?

23 A. Yes.

24 Q. And would you agree with me  
25 absolutely no harm or prejudice would flow to anybody  
using that definition if there were more reportable  
cases to the coroner?





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A. No.

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Q. You would agree with me, or

4

you disagree?

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A. No, I don't disagree with you.

6

Q. So you would agree there is no

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harm or prejudice in more reportable cases to the  
coroner?

8

A. No, the coroners might not

9

like it too much if they were called for every single  
death.

10

11

Q. Well, we are not talking here

12

about every single death, are we? If we were, then

13

my definition would be unreasonable. I am talking

14

about a reasonable definition that may result in more

15

deaths reported to the coroner.

16

A. Yes.

17

Q. And we both agree then that no

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harm or prejudice is going to flow to anybody?

19

A. No.

20

Q. So using that definition, we

21

are not going to do any violence to either the letter

22

or the spirit of the law insofar as it is set out in

23

the Coroners Act?

24

A. No.

25

Q. Now, insofar as reporting cases





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3 to the coroner is concerned, so far as it is concerned,  
4 does your own experience since July of 1980 suggest  
5 to you that your definition of "unexpected" for the  
6 purposes that you have given wouldn't be better  
7 adjusted to take into account the types of consider-  
8 ation that are included in the definition I have  
suggested?

9 A. That can be argued, yes.

10 Q. My question is, do you feel  
11 that your definition might be better adjusted because  
of your experience since July?

12 A. My definition will certainly  
13 be adjusted as a result of the experience.

14 Q. I beg your pardon?

15 A. My experience will most  
16 certainly be adjusted as a result of the experience.

17 Q. And may I take it that it will  
18 be adjusted more in line with the definition that I  
have suggested?

19 A. Yes.

20 Q. And I am not attempting to be  
21 critical, but would you agree that in a highly  
22 specialized field, such as yours, there is a danger  
23 in developing the type of rigid approach to a concept  
24 such as that that has to be guarded against?  
25





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A. Yes, I wouldn't deny that.

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Q. And a rigid approach with respect to that type of an issue might tend to cause one to lose sight of perhaps a greater public interest that there may be in any particular event?

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A. I don't know the answer to that one, it may be. I think as far as our experience goes in that area, although I accept the responsibility for the final position on perhaps that matter, that you have to remember that there were eight cardiologists who were all senior people, who were all involved in these cases and their views were obviously not greatly dissimilar, there were some differences as I have said before in the sensitivity to go in one direction or the other, but not great.

16

17

18

Q. I think you did indicate that different doctors have different thresholds in terms of reporting to the coroner?

19

20

21

A. Yes.

22

23

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Q. I take it that sort of a situation is always going to create differences of opinion?

A. Yes.

Q. And, in effect, doubt about the proper approach?





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A. Yes, I suppose that is right.

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Q. And I take it as well that the hospital may well have had that in mind in resolving doubt in favour of reporting to the coroner?

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A. Yes.

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Q. You described for Mr. Scott the procedure that was involved in reporting cases to the coroner. As I understood it at the time of death of a patient there would be four people who would be either involved in the treatment at that point, or made aware of it very shortly thereafter. They would be the Resident, the Associate Resident, the Cardiac Fellow and the Senior Staff Cardiologist?

14

A. Yes.

15

16

17

Q. And at the time of death, the group, whether they be three or four, would have a discussion with respect to the issue of cause of death?

18

A. Yes.

19

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Q. And that, I suggest, is certainly appropriate in view of the requirement of the Coroners Act to immediately notify the coroner?

21

A. Yes.

22

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Q As we have seen, it is the  
Coroner who is charged with the responsibility of  
investigating?

A Yes.

MR. HUNT: Would this be an appropriate  
time?

THE COMMISSIONER: Yes, we will take  
20 minutes.

--- Short recess

--- Upon resuming:

THE COMMISSIONER: Yes, Mr. Hunt.

MR. HUNT: Thank you, Mr. Commissioner.

Q Doctor, I would like to consider  
with you a number of the deaths in light of our  
discussion with respect to the Coroner's Act prior to  
the recess.

A Yes.

Q The way in which I propose to  
deal with it, I am going to first deal with those  
that were reported prior to March of 1981, those  
being Woodcock, Dawson and Velasquez. I am going to  
deal with Estrella separately because I am going to  
suggest to you, sir, that that case was not reported,  
contrary to the note that you drew to the Commission's  
attention in the zebra package.





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A. Yes.

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Q. At least was not reported until March the 20th of 1981, and then look at a number of the deaths between July 1st and March the 22nd, and in doing that, we will look at the cases that were reported in March of 1981.

Now, the first one that was reported was in fact the first death that this Inquiry touches, that of Laura Woodcock. You have indicated that this death was reported on the basis that it was sudden and unexpected and at the time of death there was a feeling that there was no good cause for the death; is that a fair summary of it?

A. Yes.

Q. And it was pointed out to you by Mr. Lamek that there was a note in the chart at page 54 by at that time an unnamed doctor to the effect that he was questioning the possibility of drug overdose, accidental or otherwise.

A. Yes.

Q. And you indicated you had never seen that note before?

A. Yes, that is correct.

Q. Now, we have since learned that that is -- you advanced throughout the time what you





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thought the note was in reference to and we have  
since learned that that is Dr. Weber's note, correct?

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A. Dr. Weber's note, yes.

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Q. And it has been indicated that  
Dr. Weber will be available to indicate what it is that  
he meant by that. Have you discussed it with Dr. Weber?

7

A. Yes, Weber it is.

8

Q. Pardon?

9

A. Dr. Weber.

10

11

Q. I am sorry, Dr. Weber. Can you  
indicate what your understanding of it is at this  
point?

12

13

A. Well, my understanding was that  
he was concerned about the question of some agent that  
might cause the jaundice.

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Q. And how does his note relate to  
his concern, particularly inasmuch as the note referred  
to drug overdose, accidental or otherwise?

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A. Yes, well, I think there was  
some question in his mind he believes about some other  
incident around the same time in which there had been  
some drug involvement, another inquest not connected  
directly with the Hospital, I believe.

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Q. Well, is it your understanding,  
then, that the reference in the note to accidental or





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otherwise was some reference to the possibility of an intentional overdose?

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A. I am not sure whether it was intentional or accidental. He described this as an incident outside the Hospital where a child had had jaundice and there was some question of a chemical involved.

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THE COMMISSIONER: Is it this child?

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THE WITNESS: No, it is not this child.

10

No, it is some other child.

11

THE COMMISSIONER: What is the exhibit,

12

do you know?

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MR. HUNT: That is page 54.

14

MR. LAMEK: It is Exhibit 117, sir.

15

MR. ORTVED: I have it, Mr. Commissioner.

16

THE COMMISSIONER: Thank you. Have you got that, Dr. Rowe?

17

THE WITNESS: Yes, I have.

18

THE COMMISSIONER: How does it read,

19

"Could possibly be some sort of drug overdose, accidental or otherwise".

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THE WITNESS: Yes.

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THE COMMISSIONER: But surely does this

22

not refer to Laura Woodcock? You say it refers to some other child?

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G.5

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2 THE WITNESS: No, this note refers to  
3 Laura Woodcock, but I was asked what Dr. Weber -- how  
4 Dr. Weber explained that comment.

5 THE COMMISSIONER: Yes.

6 THE WITNESS: And I said that he was  
7 referring, he said, to a drug that might cause the  
8 jaundice in this child Woodcock, and his reference to  
9 accidental or otherwise related to some previous case  
10 over which there had been an inquest and that he had  
11 appeared for, I think. I cannot give you that detail.  
You would have to get that from him.

12 MR. HUNT: Q All right, but my question  
13 I guess more specifically is was the reference in that  
14 note at that particular time one which was reflecting  
15 his concern that whatever had happened in the other  
case may be a possibility with respect to Laura Woodcock?

16 A. Yes, I think that is possibly so.

17 Q Now, this note was never drawn  
18 to your attention obviously prior to your giving  
19 evidence or preparing to give evidence here?

20 A. I do not recall having seen that.  
21 I think that Dr. Weber came to the arrest after I had  
22 written my note. He must have written his note after  
I had been there.

23 Q But is there any reason that you  
24  
25





G.6

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2 can think of as to why that type of a note, if in  
3 fact what Dr. Weber was referring to was the possibility  
4 of something that had been involved in another case  
5 being involved in this case, why that was not drawn  
6 to your attention some time either approximate to the  
7 death or certainly prior to you giving evidence before  
8 this Commission?

9 A. Well, I do not know the reason  
10 why it would not have been brought to my attention  
11 except that I think that you have to realize this note  
12 really is a written description of the sort of  
13 differential diagnosis that doctors are putting  
14 together, and he would have been awaiting, I am sure,  
15 the results of the examination and so on before he  
16 decided.

17 Q. But is it fair to infer from the  
18 fact that you were not made aware of it at any stage  
19 prior to giving evidence that that note apparently  
20 was not viewed with alarm by anybody at the Hospital  
21 who had occasion to review the chart?

22 A. No, I would think they would  
23 have regarded it in the way I regard it, which is  
24 that this is a differential diagnosis he is throwing  
25 up with no firm conclusion about any of them at that  
stage. I think if Dr. Weber had thought that there was





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some poisoning or drug overdose with a real concern,  
he would have spoken to me.

Q Well, that was my next question,  
sir. Surely if the note was intended as an alarm he  
would have done more than just make a note. You would  
have expected some verbal communication about the fact?

A Yes, I would have.

Q So as far as you are aware, the  
note was not drawn specifically to anybody's attention  
with a view of raising an alarm at that point in time?

A No.

Q Is it fair to say that inasmuch  
as that is the likely way in which it was being viewed,  
that is not the type of note that would have been  
specifically drawn to the Coroner's attention at the  
time he undertook the investigation?

A But I presume the Coroner might  
have seen the record.

Q No question about that, but my  
question is is it a fair inference that because of the  
view that was taken of this note by Dr. Weber and by  
the staff that saw it, it is not the sort of note  
that would be drawn specifically to someone's attention  
as an alarm bell?

A No, I would agree with that.





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Q Now, the next case that was reported to the Coroner, sir, was Amber Dawson, and this is a case where you have indicated that the onset of the terminal event was indeed sudden, but that in your view even though you could not be absolutely sure as to why the child died, there were good medical reasons for the baby's death and you viewed it as a borderline case for reporting to the Coroner?

A Yes.

Q This is a case, then, where obviously someone else of a differing view whose threshold perhaps for reporting was different, decided that the conditions that have to be in existence before the duty arises were in fact there and it was reported?

A Yes.

Q Notwithstanding that, you, I think indicated that you feel it was a wise decision to have reported the case?

A Yes.

Q So far as the Coroner's investigation of this death is concerned, the cause of death that was described by the Coroner is subphrenic abscess, hemiparesis of the diaphragm and congenital heart disease?





G.9

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THE COMMISSIONER: Where do we find that?

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MR. HUNT: Well, I assumed that that

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was in the chart, but that may well be in the

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Coroner's report which has not yet been filed. If I

6

undertake to file that, I can ---

7

THE COMMISSIONER: The Coroner's report,

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no.

9

MR. HUNT: The final autopsy reports I

10

think are filed.

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THE COMMISSIONER: Yes.

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MR. HUNT: But the Coroner's report

of July the 28th perhaps is not.

13

THE COMMISSIONER: This whole method

14

is confusing me. If there is an autopsy report done

15

by the Coroner, that would be incorporated in the

Coroner's report, is it not?

16

MR. HUNT: If there is not a ---

17

THE COMMISSIONER: Maybe I should be

18

asking, I do not know, but I think I could ask either

19

you or the witness for that answer, but you say there

20

could be an autopsy performed by the Hospital?

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MR. HUNT: Yes.

22

THE COMMISSIONER: But it could be

23

reported to the Coroner and from the moment it is

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reported he takes over so the autopsy would then be

conducted by him?

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G.10

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MR. HUNT: No, the autopsy generally I think is conducted by the same person the Coroner appoints.

THE COMMISSIONER: Yes, but it is conducted for him.

MR. HUNT: Yes.

THE COMMISSIONER: But in the final, do we not have whether it is the Coroner's autopsy or your own? Do we not have it in the medical report, Dr. Rowe?

THE WITNESS: In the Hospital record, Mr. Commissioner?

THE COMMISSIONER: Yes, Hospital record.

THE WITNESS: We do not usually have the Coroner's report in a hospital record. It is here in this particular case.

THE COMMISSIONER: What page?

THE WITNESS: Page 59. It is the report of the post mortem examination performed for the Coroner.

MR. HUNT: Q That was performed by Dr. Cutz?

A. Dr. Cutz, yes.

Q. On the 30th of July, 1980?

A. Yes.





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Q And just to complete that, in his report he found that the immediate anatomical cause of death was not determined, but he listed as contributing factors congenital heart disease, right hemidiaphragm paralysis?

A Yes.

Q My question to you, and I see that it probably is the situation that the Coroner's investigation statement has not yet been filed, Mr. Commissioner, and I will undertake to file that after lunch with respect to this particular death. It is dated the 18th of August, 1980, the Coroner being a Dr. D.G. Bunt.

THE COMMISSIONER: Well, just to help me out, I take it that when the postmortem examination is conducted by the Coroner, that is not the same thing as the Coroner's report?

MR. HUNT: No, the Coroner does an investigation which involves, among other things, talking to people, looking at certain charts. His investigation statement is not the same thing as the report of the postmortem examination.

THE COMMISSIONER: It will help me when I have seen it. I do not know that we have seen any of these. Have we seen any Coroner's reports, then,





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of that nature? Have they been filed?

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MS. CRONK: None have been filed,

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Mr. Commissioner, to date.

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MR. HUNT: So with respect to this

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one, I will file this one after lunch with copies,  
but ---

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MR. ORTVED: Could Mr. Hunt file the

8

one in relation to Woodcock too, please?

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MR. HUNT: I am not sure I have it,

10

but I will look.

11

THE COMMISSIONER: Yes, all right. At

12

some point I take it we are going to file all of these?

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MR. LAMEK: Yes, we have them, Mr.

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Commissioner.

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THE COMMISSIONER: Don't you think that perhaps it might be good to file them all, if you can manage it.

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MR. LAMEK: It may not be possible for this afternoon but we can probably file this afternoon the ones that we are referring to right now.

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THE COMMISSIONER: Yes, all right.

MR. LAMEK: And the others as soon as possible.

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THE COMMISSIONER: So that I will understand the coroner's business - I promise not to go into competition with him - he submits, does he, to someone a postmortem examination, at least somebody does that, perhaps submits it to him, is that correct?

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MR. HUNT: That is correct.

THE COMMISSIONER: And he puts that and any other information, whether by an inquest or by just looking around into something called the Coroner's Report.

MR. HUNT: Yes, or a Coroner's Investigation Statement.

THE COMMISSIONER: Is that statutory?

MR. HUNT: Yes, I believe it is.





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3 THE COMMISSIONER: Pardon?

4 MR. HUNT: I believe it is.

5 THE COMMISSIONER: Yes.

6 MR. OLAH: Mr. Commissioner,

7 obviously the power on your microphone isn't on,  
8 we're having some difficulty hearing you back here,  
9 sir.

10 THE COMMISSIONER: No, as I said  
11 before it is whenever I'm uncertain I start to mumble.  
12 So, this is the problem here. I'm talking about the  
13 procedure in the Coroner's Office. I don't know any-  
14 thing about it and I am just hoping somebody will  
15 tell me what happens. I would like to know - apparently  
16 even though there is a postmortem examination and  
17 that becomes a public document there is also a  
18 coroner's report which is available and Mr. Hunt and  
19 Mr. Lamek are going to produce as many of these as  
20 they can this afternoon. Am I right, is that a  
21 fair statement?

22 MR. HUNT: Yes.

23 THE COMMISSIONER: Yes, all right.

24 MR. HUNT: Q. Now, my question  
25 with respect to this particular one, Doctor, is that  
the coroner's investigation as summarized in the  
Coroner's Investigation Statement or the Coroner's





1  
2 Report indicates that the relevant postmortem  
3 examination findings and analyses involve a sub-  
4 phrenic abscess, a hemopoiesis of the diaphragm and  
5 congenital heart disease.

6 Now, you had indicated that at the  
7 time of death you felt there were good medical  
8 reasons for the baby's death, although, one couldn't  
9 be absolutely sure as to what the cause of death was.  
Is that correct?

10 A. We thought the death was  
11 due to pulmonary disease. I think I may have caveats,  
12 but I think that I thought it was...

13 Q. Well, perhaps we are not  
14 at odds. I thought you indicated that ---

15 THE COMMISSIONER: I thought the  
16 Dawson child was the one with the stomach perforation.  
17 Isn't that right? Have I got the wrong child?

18 MR. HUNT: Yes.

19 THE WITNESS: Yes, it was the one  
20 with the stomach perforation.

21 MR. HUNT: Q. This is the correct  
22 one. I don't think the Doctor and I are in disagree-  
23 ment here.

24 A. No.

25 Q. You viewed yourself a probable





1  
2 reason of the death as a respiratory failure in a  
3 chronically ill baby, but I think you also indicated  
4 that you at that time couldn't be absolutely sure  
5 that that was the reason why the child died and while  
6 you felt this was a borderline case you felt it was  
7 a wise decision to refer it.

8 A. Yes.

9 Q. Does that accurately summarize  
10 it?

11 A. Yes.

12 Q. My question is though that  
13 these findings of subphrenic abscess, hemopoiesis  
14 of the diaphragm and congenital heart disease, do  
15 they fall within the notion of good medical reasons  
16 for a cause of death?

17 A. Yes.

18 Q. Now, the next child that  
19 was reported, whose death was reported, rather, was  
20 Antonio Velasquez.

21 Now, before I ask you any questions  
22 about the death of Antonio Velasquez I just want to  
23 raise a few questions of the manner in which this  
24 was first raised with you by Mr. Lamek in chief.

25 Now, Volume 11, page 1937 through to  
page 1939 this is dealt with, sir, and I just want to





1  
2 summarize it, and Mr. Lamek, if I make a mistake,  
3 he can correct me. Essentially, sir, it was  
4 suggested to you that Dr. Freedom felt strongly  
5 that this death should be reported and he called the  
6 coroner on Sunday, August 24th. It appears from  
7 a memorandum that he prepared to you that at that  
8 time, after discussing the case with a Dr. I.V. Gartha,  
9 Dr. Gartha concluded that the case would not come  
10 under the coroner's jurisdiction and it was put to you  
11 by Mr. Lamek that the coroner didn't seem to be too  
12 interested in accepting it as a coroner's case and  
13 at a discussion on Monday a decision was made to  
14 contact the coroner again and attempt to see if he  
15 would reverse the decision. You were asked whether  
16 or not he did do that and you weren't sure but you  
17 felt that he must have done so and it was pointed out  
18 to you that the final report is on a Coroner's Act  
19 form. At that time Mr. Lamek indicated that it was  
20 not worth spending a lot of time on it in that case.

21 Now, sir, I am going to suggest to  
22 you -- oh, you were also asked whether an inquest  
23 was held and you answered no.

24 Now, I am going to suggest to you  
25 that the way that was left at that stage leaves some  
considerable doubt as to whether or not the Coroner





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had properly done his job simply because he did not accept the case on Sunday. Do you agree with me.

A. Yes, I see what you mean.

Q. And I think that is borne out on the fact that by the very next day two Toronto papers, the Toronto Star and the Globe and Mail reported in grand fashion that the coroner refused to investigate an early baby death, that the baby's death wasn't probed and the Globe and Mail indicated that an inquest was denied in an unexplained death.

Now, firstly, there was no inquest asked for I take it by the Hospital?

A. No.

THE COMMISSIONER: Excuse me, just a moment. Do you ask for inquests?

THE WITNESS: It hasn't been my practice to ask.

THE COMMISSIONER: Everybody just leaves you -- I don't see why - I thought that was up to the coroner to decide whether ---

THE WITNESS: Well, I believe you can. You can ask for an inquest.

THE COMMISSIONER: Is that statutory, do you think, Mr. Hunt?





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MR. HUNT: Well, the coroner decides whether or not he chooses to, or he feels that an inquest should be held and he makes the decision. Anybody can ask for an inquest. The point here for an inquest, Mr. Commissioner, is simply that the way it was left at that time certainly created a misimpression with respect to whether or not the coroner was doing his job and I want to make it clear at this point, Doctor, that there is absolutely no question that the coroner accepted this case after further discussion with Dr. Freedom.

THE WITNESS: Yes.

MR. HUNT: Q. Now, with respect to Antonio Velasquez, you have indicated that the cardiac problems were not the cause of his death and that he was not expected to die at the point in time when he died.

A. That is so.

Q. But there was a consideration concerning the administration of the drug naloxone?

A. Yes.

Q. And just so that I have it clear in my mind, as I understand it, there were three - preceding the administration of naloxone, there were three doses of codeine administered.





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A. I thought there were two  
doses of codeine.

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Q. Well, I thought they were  
administered at 10:30, 6:30 and 9:30.

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A. Well, I may have that  
incorrectly.

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Q. In any event, the effect of  
codeine is as a depressant, is that correct?

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A. Yes, it is a narcotic-like  
drug.

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Q. And when it was noted that  
the heart rate was slowing and the pupils were  
constricted, the baby was difficult to arouse, it  
would appear that the attending physician was of the  
view that this might be the effect of codeine.

16

A. Yes.

17

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Q. And as a result it was  
the decision to administer naloxone to counter that  
effect.

19

A. Yes.

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Q. You have indicated that there  
were two doses of naloxone given, each one was  
slightly larger than the appropriate dose?

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A. Yes.

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Q. And am I correct that it is a

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characteristic of naloxone that several doses can be given within short periods of time of each other if needed to counter the effects of the narcotic?

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A. Yes.

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Q. It was the fact that the baby went into the cardiac arrest such a short time after the administration of the second dose of naloxone that created the concern, is that right?

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A. Yes.

Q. Now, Dr. Freedom in his

memorandum to you, which is found at page 6 of the chart.

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THE COMMISSIONER: Not on mine.

This may be the one that has two page 6's.

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MR. HUNT: Well, I think this is the first page 6.

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THE COMMISSIONER: Well, you say

it is one of these, you say there is another 6 somewhere?

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MR. HUNT: Well, I believe there are two page 6's. The numbering restarts again.

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THE COMMISSIONER: Well, that may not have to happen because it is not in mine. It is a memorandum at any rate?

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MR. HUNT: Well, I can perhaps





1  
2 summarize the relevant portion, Mr. Commissioner.

3 The memorandum was from Dr. Freedom  
4 to you dated the 26th of August in which he sets out  
5 the history of the events leading to the death of  
6 Antonio Velasquez. He indicates that on his examina-  
7 tion of the facts and his own personal knowledge that  
8 naloxone is not a drug that supresses the cardio-  
9 vascular system or leaves it to irreversible hypo-  
10 tension. He recites that he conferred with Dr. Conn,  
11 an anesthesiologist and head of the Intensive Care  
12 Unit and found that that fact was corroborated and  
13 he then spoke to Dr. MacLeod, the head of Clinical  
14 Pharmacology, who advised him that naloxone or  
15 narkan, even in very toxic doses, is not known to  
16 have an adverse cardiovascular effect.

17 Now, am I right in taking from that,  
18 that notwithstanding that the baby died within such  
19 a short time of the administration of the second dose,  
20 Dr. Freedom's examination appeared to lead to the  
21 conclusion that naloxone is not a drug that has an  
22 effect on the cardiovascular system such that would  
23 bring about that result.  
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A. No - yes, that is what it  
infers, yes, I am sorry, the statement that he made.

Q. So the baby dies, there is  
some concern because the baby died so soon after the  
administration of the drug. The doctor talks to two  
other doctors, Dr. Conn and Dr. MacLeod, and they  
are concerned then that the drug affects may have  
affected the cardiovascular system would appear to  
be alleviated?

A. I don't know that they are  
alleviated, but that opinion from those people was  
that it was unlikely.

Q. It was unlikely that naloxone  
had anything to do with the heart stoppage at that  
time?

A. Yes.

Q. Now he then goes on to say:

"With these facts in hand..." And with  
those facts that he gleaned from talking to Doctors  
Conn and MacLeod, he contacted the coroner on call  
for the Sunday, that being Dr. Gartha and discussed  
the case with him. He mentioned the temporal  
relationship between the cardiovascular collapse and  
the second dose of naloxone or narkan. He also  
indicated to him that in his conference with the Head

If Gamba rejected the idea that Velasquez death might have been caused by an o/d of Naloxone, then the death was utterly unexplained and, a fortiori, should have been accepted as a Ceruzzi case!



1  
2 of the Clinical Pharmacology in the Intensive Care  
3 Unit that they felt that it was most unlikely that  
4 the dose would precipitate such a fatal event?

5 A. Yes.

6 Q. So is it not fair to infer  
7 from that, sir, that when Dr. Gartha was contacted  
8 he was told of the death, of the relationship to  
9 the administration of naloxone and that two experts  
10 have ventured the opinion that naloxone probably had  
11 nothing to do with the cardiovascular collapse?

12 A. Yes.

13 Q. And based on information that  
14 Dr. Freedom gave him, which would be the only  
15 information he had at the time, he didn't feel it  
16 was a case for the coroner to investigate?

17 A. I presume so.

18 Q. And that scenario is in keeping  
19 with your understanding in the way in which cases get  
20 reported and the recitation of certain basic  
21 facts to the coroner in that initial contact?

22 A. Yes, indeed.

23 Q. Now then at a meeting the  
24 following day concern is still expressed about the  
25 relationship between naloxone and the onset of the  
terminal event?





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A. Yes.

Q. And was there some reason why the opinions of the preceding day, from Doctors Conn and MacLeod, were now thrown into question?

A. Well I think it was discussed with a number of the senior staff of the Division of Cardiology. This matter I believe was being examined by a Committee of the Senior Members of the Division.

Q. All right.

A. The facts were known about these other opinions, but the group felt that despite that there seemed to be such a good relationship to the time of the injection, that it was not an unreasonable conclusion, however uncommon or rare, or unlikely that may be, that was still a possibility, that naloxone might have contributed to the death.

Q. So notwithstanding the opinions of the - I suppose the view was to err on the side of caution and to approach the coroner again with a view to seeing whether he would take the case on to investigate it?

A. Yes.

Q. And that was left up to Dr. Freedom?

A. Yes.





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Q. And at some point Dr. Freedom  
and Dr. Garth<sup>a</sup> obviously spoke again?

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A. I believe so.

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Q. And the case was taken on  
by the coroner and investigated?

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A. Yes.

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Q. And you had indicated yesterday  
that in your view there was no suggestion of digoxin  
involvement in this death?

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A. No.

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Q. The only concern was that of  
naloxone?

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A. Yes.

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Q. Now, Dr. Rowe, you drew to  
the attention of the Commission the fact that contained  
in a package that you referred to as a Zebra package,  
was a note by Dr. Schaffer, to the effect that the  
case of the death of Janice Estrella was reported  
to the coroner and it was concluded not to be a  
coroner's case?

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A. Yes.

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Q. Now first of all, what is the  
Zebra package?

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A. The Zebra package is an  
independent record that is kept in the Cardiology

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2 Division. The reason for this is that it is a method  
3 of capturing information of data that will be  
4 important in the long term of the management of  
5 children with heart disease. It is on a special  
6 form which identifies different cardiovascular  
7 points about the patient that can be coded and put  
8 into digital form for later entry into a computer  
and retrievable systems.

9 Q. Now does the hospital not  
10 usually keep a record other than something that might  
11 be in a Zebra package with respect to cases that are  
12 reported to the coroner?

13 A. Does the hospital keep a record?

14 Q. Keep a record of the fact of  
15 a case having been reported to the coroner?

16 A. I think there is something in  
17 the Medical Records Department.

18 Q. It is called a Hospital Report/  
19 Coroner's Case?

20 A. I'm not exactly sure but I  
21 think there is some method.

22 MR. LAMEK: Mr. Commissioner, if Mr.  
23 Hunt will forgive me I have a copy of the contents  
24 of the Zebra package in the Estrella case, and I have  
25 no further copies of it, but it does contain a notation





1  
2 that Dr. Rowe has referred to and if he can identify  
3 these as the contents of that package it can be  
4 marked as an exhibit and copies can be prepared  
5 later.

6 THE COMMISSIONER: Yes, all right.  
7 Do you want to look at it before it is committed?

8 MR. HUNT: I had the opportunity to  
9 look it on another occasion and I am quite content  
10 with that.

11 THE COMMISSIONER: Can we have a number  
12 please, Exhibit 149.

13 THE WITNESS: Yes, I identify that.  
14 ---EXHIBIT NO. 149: Zebra package in the case of  
15 Janice Estrella.

16 THE COMMISSIONER: Is there something  
17 significant about the Zebra, that is all I am asking,  
18 is it just because it is a Z?

19 THE WITNESS: No it was originally  
20 identified in other records by having stripes down  
21 one side, so it became popularly known as a Zebra  
22 record.

23 THE COMMISSIONER: There are none on  
24 this one. Do you want it, do you need it?

25 MR. HUNT: I don't want it, I don't  
need it for the purpose of these questions, but





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perhaps the doctor would, I don't know.

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THE COMMISSIONER: It will be available  
I guess this afternoon or tomorrow for counsel?

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MR. LAMEK: Yes.

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MR. HUNT: Q. Doctor, have you seen  
any other records in this case having been reported  
to the Coroner in January of 1981?

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A. No.

9

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Q. Other than that note in the  
Zebra package?

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A. No.

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13

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Q. And when you saw that note in  
the Zebra package, was that the first time that there  
had ever been any suggestion to you that the case  
had been reported in January?

15

A. Yes.

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Q. And would you agree with me  
that the note as found in that is a very cryptic  
one?

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A. It is short.

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21

THE COMMISSIONER: What page is this  
cryptic or short note on, are you going to read it?

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MR. HUNT: No.

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Q. Doctor, just so that the  
record is clear could you indicate what Dr. Schaffer's





1  
2 note is written in the post operative progress notes  
3 of the patient, the Zebra package, and it is dated  
4 11.1.80 and it is 3:00 a.m. and he has the following  
5 statement underneath it:

6 "Cardio pulmonary arrest, unable  
7 to resuscitate. Pronounced dead at  
8 3.. something 5:00 a.m., parents  
9 notified, Dr. Rogerson notified  
(answering service)..."

10 Then he has got, Dr. Schaffer the Fellow has his  
11 name after that line, and then he says underneath  
12 that:

13 "Dr. Duncan notified. Coroner's Office  
14 notified. Felt not to be a Coroner's  
15 case."

16 He has got his signature again, and then underneath  
17 that it says:

18 "Consent for postmortem agreed".

19 Q. Now, you have indicated that  
20 the first you were ever aware of that was, of the case  
21 having been, some suggestion it was reported in  
22 January, was when you saw that note that you have  
23 just read?

24 A. Yes.  
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Q. Now had the case been reported in January, is that not something that you would have been made aware of in the normal course of the day-to-day activity at the Hospital?

A. Yes.

Q. And given the short nature of the note, the fact that you were not aware of it prior to seeing the note, the fact that you have never seen any other indication that it was reported in January, and the fact that you normally would have expected to be made aware of that fact: Are you satisfied yourself that that case was reported in January?

A. Well, if the Cardiac Fellow made that note I would have to believe that he meant it. I have no reason to believe that he would write a note like that unless he had done it.

Q. I'm going to suggest to you that there is no record in the Coroner's Office of the case having been reported and at the appropriate time, Mr. Commissioner, you will hear evidence of that. But given that fact, assuming that to be a fact, along with the other information you have, are you able to see any explanation, I am not suggesting anything sinister here, as to how that note could get





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in there without the Coroner having been notified?

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A. I can't see how it would have been put there unless what was done was done, what was said to have been done was done.

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Q. Let us put that aside for a second. At the time Janice Estrella dies she was I think as you have described one of the sickest babies at the Hospital?

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A. Yes.

Q. Is there any reason why Janice

Estrella would have been a reportable case at the time she died?

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A. For me, probably not. I don't know of course what Dr. Schaffer's reason for ringing the Coroner was.

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A. Well, I am not sure by any stretch of the imagination. I do not think I would have referred the patient to the Coroner because I think there were good medical grounds for expecting the death. But again, it is the gray zone of the Act and I do not know why Dr. Schaffer would do it except that he may have had some concerns about the digoxin levels at the time and may have wanted to ask the Coroner whether that meant it should be under the Act.

I am speculating here, but I think that is possible, and the Coroner may have decided -- well, you say he did not decide, but it would not have surprised me if the Coroner had said that he was satisfied with that description.

Q I take it that if someone was notified of that at that particular point in time they would have been, in the normal course, given the description of this child's disease and clinical condition as you have described it, along with any query with respect to digoxin?

A. Yes.

Q And that would have included the description of a very sick baby?

A. Yes.





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Q Now, I would like to leave the other cases that were investigated by the Coroner in March until the end and go back to July of 1980 and look at a number of the deaths that we have discussed.

Again, I am just going to look at these from the point of view of this question of reporting them to the Coroner.

A Yes.

Q The first one I would like to look at is Andrew Bilodeau. This was a baby that died by your description from a sudden onset of terminal events on July the 22nd of 1980 at 1:27 a.m. My question here again involving reporting to the Coroner arises from the letter Dr. Vera Rose sent to Dr. Patel in Brantford concerning the death of Andrew Bilodeau dated August the 6th. It is in the chart, Exhibit 42, Mr. Commissioner, page 5 where, in the opening paragraph, Dr. Rose advises Dr. Patel, I will perhaps read the paragraph:

"I am enclosing the final summary report of this little patient of yours who died rather suddenly and unexpectedly on the night of the 22nd of July, 1980."

Now, Dr. Rose is writing to another doctor and has described the death as sudden and unexpected?





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A. Yes.

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Q Assuming Dr. Rose was applying

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a reasonable interpretation to that, is that not one

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of the very conditions that imposes a duty on someone

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to report the case to the Coroner?

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A. Yes, if she really thought it

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was unexpected.

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Q Well, given that we have one

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doctor corresponding with another doctor describing

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it as sudden and unexpected, would it not be fair to

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assume that the same interpretation that was given

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to those words for the purpose of this letter could

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be applied to a review of the death for the purposes

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of the Coroner's Act?

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A. That could be so, but I do not

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believe that was the way she was using those words.

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Q Well, the problem I am having

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is that there does not seem to me to be any good

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reason for applying any different definition to the

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words when you are coming to consider the Coroner's Act?

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A. Well, that is an opinion you can

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hold, I suppose.

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Q Well, could you help me? Could

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you give me that reason I am looking for?

A. Well, I think that the language





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that is used by physicians in relation to, say, the Coroner's Act as opposed to the language they use between one another and in letters of this sort does not necessarily have the same meaning at all.

Q. Well, is there any reason why the Coroner's Act could not have the same interpretation applied to it?

A. No.

Q. I mean, we have looked at the practicalities of reporting where that condition exists is a simple phone call. It is of no inconvenience to the Hospital and there is no prejudicial or harmful effect flowing to anybody?

A. Yes.

Q. So it would seem to me there is no good reason for applying some different interpretation to those words when you come to considering reporting it to the Coroner?

A. Except that I do not think in this letter she means anything like the same sort of thing as the Coroner's Act because she has already said here that this is truncus arteriosus with probable truncal valve abnormality, and the mortality in the management of this patient is 90 per cent or something like that. We all recognized at the time





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of this death that this patient had a very short survival ahead, and I do not think that I would regard that description in her letter as being valid for the purposes of a discussion in this room.

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Q Well, I see that you have your views as to unexpected; Dr. Rose obviously has hers and we do not know what they are at this moment, but she has used this phrase ---

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A I know what they are though.

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Q And you have tried to explain them to us, I take it, in your explanation as to what she meant?

A Yes.

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Q But is it not, sir, fair to say that given the fact that we have a different description being applied to this death for purposes of considering reporting to the Coroner and a different description applied for the purpose of reporting to the referring physician, are we not into an area here where at the very least we have got some doubt?

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A I do not think so in this particular case at all.

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Q Well, would you go this far with me that in light of what at least appears on its face to be that, that this might be one of those cases





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where it would have been a wise decision at the  
very least?

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A. No, I do not. I think looking  
at it from your point of view, yes, but looking at it  
from the internal arrangement of when we saw that  
child and what we discussed afterward, I would say no.

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Q So we are left, then, I suppose  
waiting for the explanation of sudden and unexpected  
that will clear up whatever appears on its face to be  
the cause of some doubt about at least the catego-  
rization.

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MR. ORTVED: Doubt in Mr. Hunt's mind,  
not in Dr. Rowe's.

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MR. HUNT: Q Well, would you agree  
with me that on the face of things at this point in  
time there would appear to be considerable room for  
some doubt about how you categorize this death?

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MR. ORTVED: That has not been Dr. Rowe's  
evidence. I know this is cross-examination, but he has  
got to have his evidence put to him fairly.

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MR. HUNT: Q I just asked a question,  
whether you would agree with me that on the face of it,  
I know you indicate you know more about what Dr. Rose  
meant, but on the face of it, surely we have a  
situation here where there would appear to be some





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doubt about how you are going to categorize a death?

A. Not for me there is not.

Q. All right. Well, we will look next, if we could, at David Taylor, who died on July the 27th, 1980 at about 12:10 a.m. You have described the death of David Taylor as being sudden but not unexpected, given the condition that he was in at that point in time.

Now, what I am concerned with again here is that in the chart we have at page 0 Dr. Freedom's letter to Dr. Connors reporting on the death of David Taylor. He says in his opening line:

"As we talked about on the morning of the 28th of July, this infant unexpectedly sustained a cardiac arrest early in the morning of July 27th and could not be resuscitated."

Then we have in addition -- well, perhaps I will deal with that firstly.

Again we have your categorization of this death as sudden but you, on the definition you were using at that time, would not have classified it as unexpected?

A. No.

Q. We have Dr. Freedom telling





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2 Dr. Connors that it is an unexpected death. Again,  
3 I am suggesting to you, would you agree with me,  
4 there would appear to be no good reason for applying  
5 any kind of different interpretation when it came to  
6 deciding whether to report this case to the Coroner?

7 A. Well, I think the same thing  
8 applies to that case as the previous case. I do not  
9 think Dr. Freedom, in discussing with us, would have  
10 said that that arrest was -- he would agree it was  
11 sudden but I do not think he would say it was  
12 unexpected in terms of the Coroner's Act.

13 Q. This is using the definition that  
14 you are going to change for your own purposes?

15 A. And which we have changed for  
16 several other purposes during the course of this  
17 period of time. We have used "unexpectedly"  
18 differently in our conferences, for example.

19 Q. Now, Dr. Bain in his report with  
20 respect to David Taylor indicates that he was placed  
21 in the Category 1(b) because it was thought before  
22 the autopsy that perhaps he died a little earlier than  
23 expected. Now, I take it you would agree with that  
24 statement by Dr. Bain, that is, that before the  
25 autopsy it was thought that perhaps he died a little  
earlier than expected?





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A. Well, I think you could interpret it that way. I am not sure that I would completely agree with that, but I think that is a reasonable statement by one physician about the situation. We knew this baby had an extremely severe disease and it is a question of being able to predict when the moment of death might occur.

Q. Well, if the baby died a little earlier than expected, does that not mean that his death was unexpected?

A. That would be the case if you made that assessment. Dr. Bain did not make that assessment at the time, of course. He made that assessment much later. We are talking about the moment of death, are we not?

Q. That is what I would think we are talking about.





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Q. I'm not trying to be smart,  
but if your evidence is that the fact the baby died  
a little earlier than expected does not mean that he  
died unexpectedly...

A. No, I think that if Dr. Bain  
said that he died a little earlier than expected, you  
would have to suggest that that is unexpected.

Q. All right. At the very least,  
I suggest we've got some doubt here about the expected  
nature of the baby's death.

A. From Dr. Bain?

Q. Well, that is not unfounded.

A. No, Dr. Bain has made that  
statement, I know.

Q. You would agree there would  
be a basis for that doubt?

A. Well, he is entitled to his  
opinion on that, just as we are entitled to our  
opinion on it. That was made a lot later than our  
opinion.

Q. Fair enough. But given what we  
see here, is this not a case that really, at least  
like Dawson, you could say that it would have been  
wise to have reported this one?

A. I personally wouldn't have felt





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the obligation to do so in this case.

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Q. I appreciate, sir, your using your definitions at the time, you wouldn't have felt the obligation to report, but looking at the basis for doubt that appeared to exist at the time, whether or not you were aware of it, wouldn't it have been a wise decision to have reported it?

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A. I wasn't aware of any doubt about that at the time.

Q. But you agree that there certainly is room for a view of this particular death as unexpected?

A. I don't agree with that.

Q. I didn't ask you to agree with it, I said you would agree there is room for a view?

A. There is always room for a view, yes.

MR. HUNT: Would this be an appropriate time, Mr. Commissioner?

THE COMMISSIONER: Yes, all right, until 2:30.

MR. ORTVED: Mr. Commissioner, just so that we don't put Mr. Hunt to more trouble in terms of going back to the coroner on more than one occasion. If he is getting reports for us in relation to certain





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3 of the cases he has analysed, I'm just wondering if  
4 he can get reports for us in respect to those cases  
5 that were on the initial list and in respect to which  
6 we prepared but which Mr. Lamek may not have gone into  
in detail and they would be --

7 THE COMMISSIONER: Coroner's reports?

8 MR. ORTVED: There are 16 in number,  
9 just to analyse what was done by the coroner's office  
10 because I think I may want to use them in re-  
examination.

11 THE COMMISSIONER: All right.

12 MR. HUNT: I'm still not sure what it  
13 is.

14 THE COMMISSIONER: He wants the  
15 coroner's reports I think it is.

16 MR. HUNT: Coroner's reports, but of  
17 what nature. Is this the dispatch report, is this the  
18 coroner's investigation statement?

19 MR. ORTVED: Well, I don't know, it is  
20 the report on the investigation that Mr. Hunt made  
21 reference to earlier. I have not seen these myself,  
22 Mr. Commissioner, but whatever is being produced in  
relation to --

23 THE COMMISSIONER: Mr. Lamek, can you  
24 help us?  
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3 MR. LAMEK: Just one thing, Mr.  
4 Commissioner. I think we are running a severe risk  
5 here of blending two phases of an investigation. I  
6 think there are two kinds of coroner's reports and  
7 we've got to be aware of them because certain deaths  
8 were reported to the coroner as they occurred and  
9 Mr. Hunt has been speaking to Dr. Rowe about those  
10 this morning.

11 A number of additional cases became  
12 coroner's cases after the events of March, 1981, and  
13 with respect to those there was no contemporaneous  
14 investigation by the coroner with the death of the  
15 child. Those, I suggest, belong more properly in  
16 the second phase of this inquiry going into the  
17 investigation by the coroner and then by the police,  
18 whereas, the reports relating to the deaths which were  
19 reported at the time of the death and investigated at  
20 the time of the death I think should be produced at  
21 this stage.

22 THE COMMISSIONER: I have some -- no  
23 doubt you have thought this out but it does seem to  
24 me that if the coroner has given some sort of an  
25 opinion, as I imagine he does in his reports as to  
the cause of death, it might have something to do  
with the first phase of this.





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MR. LAMEK: Except, Mr. Commissioner, it relates to -- essentially he took the cases really to stay involved with the police investigation.

THE COMMISSIONER: That's right.

MR. LAMEK: There was no independent coroner investigation with respect to those which he assumed after March '81. That is my understanding of it.

MR. HUNT: That's my understanding of it, as well.

THE COMMISSIONER: But are there not facts disclosed in the coroner's reports that might be of assistance to us. I don't know.

MR. LAMEK: Well, let us take a look at them and we can decide whether they are appropriate or not.

MR. ORTVED: Mr. Commissioner, I don't want my friend to be mislead. I am talking about 16 cases that were reported in the epidemic period.

THE COMMISSIONER: Yes.

MR. ORTVED: Not reported in March, I'm talking about 16 separate cases that were reported to the coroner, not all of which have been dealt with in the 36 cases.

THE COMMISSIONER: Some of them are





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2 outside the 36 cases?

3 MR. ORTVED: Some of them are OR  
4 deaths, some of them are ICU deaths, some of them are  
5 ward deaths and there is a total of 16 in number and  
6 I can give you the names of those to Mr. Hunt.

7 THE COMMISSIONER: Do you want to have  
8 them?

9 MR. ORTVED: Yes, please.

10 THE COMMISSIONER: Could I ask why?

11 MR. ORTVED: Just to analyse what was  
12 the response of the coroner's office in relation to  
13 the whole 16 deaths.

14 THE COMMISSIONER: Well, I don't see  
15 for any reason if they are available you can't look at  
16 them. I don't promise to receive those as exhibits.

17 MR. ORTVED: No, I don't promise to  
18 tender them as exhibits, I'm just anxious to have  
19 them for the purpose of my re-examination.

20 MR. HUNT: Perhaps we could discuss it  
21 with my friend at lunch and we will come up with a  
22 solution.

23 THE COMMISSIONER: Yes, all right.  
24 Anything else then?

25 Until 2:30.

--- Luncheon adjournment.

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2 --- Upon resuming at 2:30 p.m.

3 THE COMMISSIONER: Mr. Hunt?

4 MR. HUNT: Yes, thank you, sir.

5 MS. CRONK: Mr. Commissioner, with  
6 your permission, if I may, just for a moment. We  
7 made, over the lunch hour, Mr. Commissioner, a copy of  
8 what we understand to be the coroner's investigation  
9 statement in respect of nine of the 36 children with  
10 whom we are concerned. These are the ones, again,  
11 according to our information, that were reported by  
12 the hospital to the coroner's offices.

13 The only additional reported case is  
14 that of Laura Woodcock and I understand that Mr. Hunt  
15 will be producing the coroner's investigation  
16 statement of that. So, I have requested these be  
17 marked as a bundle.

18 THE COMMISSIONER: What did they  
19 look like?

20 MS. CRONK: It is a one page document  
21 and at the top right hand corner it discloses the  
22 name of the child.

23 THE COMMISSIONER: What does it say in  
24 the body of it? I don't want you to read it out, but  
25 does it give a reason?

MS. CRONK: It is a standard form,





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2 simply filled in by the applicable coroner, Mr.  
3 Commissioner, and at the bottom section there are  
4 details of the investigation and in the middle section  
5 there is a stipulated cause of death.

6 THE COMMISSIONER: Yes, all right,  
7 and we want to put them all in?

8 MS. CRONK: We will have copies of  
9 these made for other Counsel by tomorrow morning,  
10 Mr. Commissioner. There is a bundle of nine. Would  
11 you like the names of the individual children?

12 THE COMMISSIONER: Yes, if you  
13 wouldn't mind, can you read them out?

14 MS. CRONK: Amber Dawson, and that  
15 statement is dated August 18th, 1980. That date is  
16 not necessarily, Mr. Commissioner, the date of the  
17 reporting to the coroner but the date of the statement.  
18 The next one is Antonio Velasquez, dated December 12th,  
19 1980; the next one is Kevin Pacsai, dated March 17th,  
20 1981; the next is Janice Estrella, dated April 7th,  
21 1981; the next is Allana Miller, again dated April 7th,  
22 1981; Justin Cook, dated April 7th, 1981; John  
23 Onofre, dated July 28th, 1981; Brian Gage, dated  
24 April 12th, 1982 and David Taylor, also dated April  
25 12th, 1982.

THE COMMISSIONER: Yes, all right,





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2 thank you. What number is that?

3 THE REGISTRAR: 150.

4 THE COMMISSIONER: Exhibit 150.

5 ---EXHIBIT NO. 150: Coroner's investigation  
6 statement in respect of nine  
7 children.

8 THE COMMISSIONER: Yes, Mr. Hunt?

9 MR. HUNT: Thank you, Mr. Commissioner.

10 Q. Doctor, I would like to turn  
11 to the case of Kelly Ann Monteith who died on the 18th  
12 of August, 1980. You indicated in your characteriz-  
13 ation of the terminal event that the events were  
14 sudden and I believe you expressed the fact that there  
15 was a measure of surprise when she died because she  
16 had been stable for two or three days prior to that.  
17 Is that a fair summary of the portion of your  
18 assessment of this particular death?

19 A. Yes, I think so. I'm not sure  
20 what degree of surprise I had.

21 Q. There was a measure of some  
22 surprise I take it.

23 Now, Dr. Bain in his report indicates  
24 that there was some feeling prior to the post mortem  
25 that perhaps she should not have died when she did and  
as far as you are concerned is that an accurate  
statement?





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3 A. Well, I think I'm not sure  
4 exactly, that I can recall what I said in the  
5 transcript, but I believe that in this particular  
6 condition, sudden death can be expected at any time  
because it is an infraction of the heart.

7 Q. Well, are you able to indicate  
8 whether there was some feeling on the part of anyone  
9 prior to the post mortem that perhaps she should not  
have died when she did?

10 A. I don't know whether anyone  
11 said she should not have died when she did. There  
12 may have been some discussion about whether it was  
13 expected at that very specific moment in time.

14 Q. It would appear that in any  
15 event it was felt that the post mortem might throw  
16 some light onto the question of her death, if in fact  
17 there was a feeling that she died sooner than she  
might have been expected to.

18 A. I would think that would be a  
19 good reflection of how we generally operate on these  
20 matters.

21 Q. All right. Now, my concern  
22 then, sir, is that we have already looked at the  
23 question of the position of the coroner in cases where  
24 they can be catagorized as reportable.  
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A. Yes.

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Q. And one of the requirements of the Act certainly is where it may require further investigation -- we saw that earlier.

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A. Yes.

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Q. And the hospital has indicated that where there is doubt about the cause of death, doubt about whether it should be reported then it is a reportable case as far as they are concerned.

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A. Yes.

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Q. Now, if there was in fact prior to or at the time of the death of Kelly Ann Monteith, a death which is sudden, a feeling that perhaps she should not have died when she did, isn't this exactly the sort of case that the coroner is supposed to and is charged with the responsibility of investigating to see whether or not there is a concern?

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A. Well, I think that that is true if you look at it in your light. I think if you look at it from the point of view of the physicians looking after the patient, this individual had a condition which we know is subject to sudden death and in this baby a post mortem was obtained. What the post mortem revealed was even worse than we had thought and I do not think that in that situation, if we had found that





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there was no infraction of the heart, then I think  
there would be no question of what would have been  
done.

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Q But as we have seen that is not really the way the procedure is regulated, is it, in terms of the Coroner?

A I realize this is not what you would necessarily read from the Act, but that is very common practice in medicine I think.

Q It would appear to have been, or perhaps was something that occurred in this case, and maybe in one or more other cases, but it is certainly not what the provisions regulating the investigation would appear to dictate?

A From your reading of it I would think that is true, but from the reading of most physicians the way in which it works is that if there is any reasonable medical explanation for the death it is not regarded as a case the Coroner has any interest in.

Q But if there is some feeling at the time of death that a person has died sooner than they were expected to die, if there is any question about it, surely then the question is one that is to be resolved by the Coroner?

A I wouldn't agree in this case. This case has an infarction type problem in the heart that can die at any time. If someone expressed a





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question of maybe it died before the operation was planned or something, that is one thing, but I would not regard that case as a case which ordinarily interests the Coroner at all.

Q Can you account in any way then for the feeling that Dr. Bain expresses that existed prior to the post mortem, that perhaps she should not have died when she did?

A I don't know why he thought that.

Q Doctor, Richard McKeil is the next case I would like to turn to. Now, he died at 3:45 a.m. on October 15th. You in your description of his terminal events agreed they could be described as sudden.

MR. ORTVED: Is there a reference?

MR. HUNT: I beg your pardon.

MR. ORTVED: Is there a page reference?

MR. HUNT: A page reference, yes, that would be at page 2262, lines 3 to 20, and that is Volume 13.

Q Now if I am correct this patient - there were in the chart with respect to this patient a number of references to problems with digoxin.

A Yes.

Q And this is the patient, if I am





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correct, that had a digoxin reading on October the 14th, which is the day before he died, of greater than 4.7 nanograms per millilitre, is that your recollection?

A. I would have to check that, but I believe that is correct.

Q. Now it is clear that how much greater than 4.7 nanograms per millilitre was not ascertained?

A. That is right.

Q. Now when there is a death that is sudden, and I suppose there is no dispute about that, and the day before that occurs there is a question about the level of digoxin in that patient, would you not agree with me that that is something that requires some further looking into?

A. Well, this - that would be true if this was taken in isolation. This patient had digoxin levels that were a problem, at least appeared to be a problem, on several occasions. There is some very good question about whether those digoxin levels reflect the real elevation of the serum level of digoxin because of the times at which they were taken. The time in which the sample was taken after the administration of the drug. On many occasions the patient's level was well within the therapeutic range.





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On the few occasions when it was above there seems to be good evidence that it was something to do with the time at which the sample was taken.

So I think that, yes, if you have very high levels you have some questions, obviously. But if there is another explanation for that, I think, no.

Q But even in a case such as this where there had been some other indication of high levels, surely it required some further consideration to determine whether or not the level of greater than 4.7, which we don't know how much greater it was, at a time approximate to the death had anything to do with it?

A Not if it was taken at the inappropriate time.

Q But somebody was going to have to look into that question, weren't they?

A Yes, but that would be done by the physicians.

Q Well, would you not agree with me that the mere fact that that is the case at the time of death raises questions that have to be looked into?

A By the physicians.





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Q Well, go with me this far, do  
they raise questions that have to be looked into?

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A. Yes.

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Q And where a matter requires  
further investigation, isn't that clearly one of the  
cases that there is a duty to report to the Coroner?

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A. Not if it was felt there was a  
good explanation for the ---

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Q Well, presumably if it was felt,  
if it was felt not after the investigation?

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A. Not if it was felt after the  
investigation? Even if there was a good reason for  
it even after the investigation.

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Q No, but you have indicated that  
if it was felt there was a good reason for it then  
there would be no duty to report?

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A. No.

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Q But that assumes there is going  
to be some investigation carried out in order to get  
to the point where ---

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A. Yes.

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Q Well, isn't that my point, sir,  
that where the circumstances require an investigation  
that is precisely one of the cases that the Act  
requires be reported to the Coroner?

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A. Well, I wouldn't see it that way at all.

Q Do I take it from what you are saying, that there is read into the Coroner's Act, or perhaps I shouldn't put it that way. Do I take it from what you are saying that it seems to be, or was accepted in this case, that there is room for an investigation of cases falling within that type, by the physician in charge?

A. Yes.

Q And would you agree with me that that does not appear to be contemplated by the provisions in the Coroner's Act?

A. But we have been told that. I agree it doesn't say that in the Act, and we have been told that by coroners.

Q You have been told ---

A. That it is an internal judgment.

Q You have been told to carry out your own investigation. Well, there is no question that there is judgment involved in certain of these questions that go to the conditions, but one of them is very clear and that is "where it requires further investigation".

A. Well, traditional practice as I

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see it, and has been reflected in the way that people for years have looked at this problem, is that they make a judgment call, and I would think that in issues like digoxin levels of a therapeutic, where there have been therapeutic difficulties and so on, a matter for an internal judgment before calling the coroner.

Q. Even where the level in question is not a therapeutic one?

A. If it is an incorrect level from obtaining it at the wrong time, yes.

Q. Well, let me put it this way, even where the level in question on its face appears to be not a therapeutic one?

A. Yes. No, I am sorry, I am only saying that in relation to a therapeutic level where it is at the wrong time.

Q. But that is a question that would be answered by an investigation into it?

A. Yes.

THE COMMISSIONER: I have forgotten, does the medical record, the Hospital record, does it disclose the time of the taking of the sample?

THE WITNESS: Yes, it does.

THE COMMISSIONER: What are the times, please, have you got those?





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THE WITNESS: I have them here in detail. A digoxin level of 4.6 was recorded on the 16th of September.

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THE COMMISSIONER: I think it is greater than 4.7 we are worried about.

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THE WITNESS: I was simply using that example, Mr. Commissioner.

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THE COMMISSIONER: No, I can understand that, well, certainly by all means give me that too. 4.6 was taken when?

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THE WITNESS: The 16th of September, 25 minutes after the dose of digoxin had been administered. A level of 3.4 was obtained on the 3rd of October, one hour after the dose. And a dose on the 14th of October, I am sorry, the level on the 14th of October was greater than 4.7 at 09.40, the last dose of digoxin having been given at 6 o'clock, 0600.

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THE COMMISSIONER: Yes, all right.

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MR. HUNT: Q. So Doctor, the next case that I was going to draw to your attention was that of Brian Gage. My question here was similar to a question that I had with respect to Richard McKeil.

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Brian Gage died on September the 25th, in the early hours of the morning and you described the --- I am sorry, there is a note in the reporting





BB.9

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2 letter to the fact that this child died suddenly at  
3 that time. My concern was that there appeared to be  
4 a level of 3.5 nanograms per millilitre on the  
5 morning prior to the death, as reflected in the chart.  
6 Do I take it that your view with respect to any  
7 inquiries concerning the relationship of admini-  
8 stration of doses, and the relationship of them to  
9 death, in this case, would be the same as you have  
expressed for Richard McKeil?

10 A. No. They are not, because in  
11 this case as far as I am aware there was no digoxin  
12 given, I think that was a level that was appropriately  
13 sampled, and there was no digoxin given for 24 hours,  
14 but the level in itself is not, in my view, remarkable  
15 in a patient who was in very severe heart failure. So  
16 I would not regard 3.5 as very spectacularly abnormal  
17 in a patient in whom we had also 24 hours before death  
discontinued the drug.

18 Q. Even on this case then your  
19 view would be it doesn't require any kind of real  
20 consideration, or investigation by anyone before  
coming to a conclusion?

21 A. No.

22 MR. LAMEK: Mr. Commissioner, I hope  
23 Mr. Hunt will forgive me, there is one thing that I  
24  
25





BB.10

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think should be corrected now before we forget about  
this and move to re-examination some weeks from now.

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Dr. Rowe referred to a level of 4.6  
taken on the 16th of September.

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THE COMMISSIONER: Yes.

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MR. LAMEK: Which I thought I heard  
him say was on a sample drawn 25 minutes after the  
time of the dose, this is at page 159 of the McKeil  
chart.

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MR. LAMEK: Now, in fact, I think I am right that on page 86 in the med sheet it appears that the dose on the morning of the 16th was given at 5:30, not at 9:00 o'clock, and therefore, this sample would have been drawn four hours after the dose; I think I have that correctly.

THE WITNESS: I obviously have a different impression.

MR. LAMEK: Perhaps I could show it to you, Dr. Rowe.

THE WITNESS: That is correct, I am sorry. That is a mistake on my part.

THE COMMISSIONER: What is the ---

MR. LAMEK: The dose appears to have been administered, Mr. Commissioner, not at 9:00 o'clock but at 5:30 in the morning.

THE COMMISSIONER: And the total time?

MR. LAMEK: Three hours prior to the sample being drawn.

THE WITNESS: If I may add, Mr. Commissioner, that would still have the same argument as far as I am concerned.

MR. LAMEK: Sorry, four hours, 5:30 to 9:25.

THE WITNESS: It would be a four hour





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interval.

THE COMMISSIONER: Yes, all right.  
So the argument is not as strong. It is the same  
argument but not as strong.

THE WITNESS: The same argument but  
perhaps not as strong.

MR. HUNT: Q. Dr. Rowe, John Onofre  
died on December the 6th at 4:15 a.m., and am I right  
that your view is that this death was not only sudden  
but unexpected as well?

A. I have on my notes "sudden (?)  
unexpected." That was on the 9th of December, yes.

The reason that I queried the unexpected issue  
was simply that he had an arrhythmia and he had sepsis  
as it later turned out. But the issue was the arrhyth-  
mia, the implication of the arrhythmia at the time.

Q. So that gave you some question  
with respect to the unexpected nature of the death?

A. No, I think the arrhythmia was  
the question of whether that had initiated the sudden-  
ness of the death, perhaps unexpected. Perhaps  
I should concede that.

Q. I was just going to say perhaps  
there is at least some doubt about it?

A. Yes.





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Q. So based on that, again, are we not -- I should not say again, but are we not dealing here with the case that would appear to fall squarely within one of the conditions set out in the Coroner's Act for reporting?

A. Yes, it would. We, I guess, took the position that the patient had a severe malformation and known arrhythmia and might have died at any time. We obtained a post mortem and confirmed that and had even more information.

Q. So in effect, there was an inquiry conducted to look into the question of death?

A. Yes.

Q. And again, is that not what the coroner is there for?

A. Yes.

Q. Now, the next baby, Dr. Rowe, is Darcy MacDonald who died on December 13th, 1980 in the early morning hours. Now, am I correct that this is another baby where the question of digoxin and its effect is referred to on more than one occasion in the charts with respect to his progress?

A. There is a note to that effect.

Q. The note is with respect to the possibility of digoxin toxicity, is it not?





CC4

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3 A. It is also with respect to a  
4 vagal reflex, arrhythmia and respiratory troubles.

5 Q. But where you have that kind  
6 of question left unanswered at the time of death, are  
7 we not again into a situation where some sort of  
8 investigation is needed?

9 A. It depends upon who makes the  
10 observation.

11 Q. In what sense?

12 A. In the sense if the cardiolog-  
13 ist, if the senior cardiologist who is involved with  
14 the patient makes that statement, then there is a  
15 real concern. If the statement is made by a resident  
16 who is just starting his training in the area, the  
17 validity is not quite as strong. So that presumably  
18 if the resident makes that statement, then the staff  
19 person will make some comment on it and accept or  
20 reject it depending upon the evidence.

21 Q. But certainly, I would think,  
22 sir, no matter who makes the statement, it would  
23 certainly raise a question that had to be addressed?

24 A. By the staff cardiologist.

25 Q. As you say, depending on who  
makes it, then the depth of the inquiry that will have  
to be made into it may vary?





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A. Yes.

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THE COMMISSIONER: Mr. Hunt, could you tell me where in the hospital record the question about toxicity is?

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MR. HUNT: Yes, I believe you will find it on page 31, page 46 and page 58. Page 58 was the arrest note --

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THE COMMISSIONER: Yes.

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MR. HUNT: -- where the resident listed four possibilities, the final one being dig toxicity.

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THE COMMISSIONER: The other one is page 48?

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MR. HUNT: I am sorry, I think it was page 47.

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THE COMMISSIONER: 47, and?

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MR. HUNT: And page 31, where the question was raised in Hamilton, I believe.

18

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Q. Now, the discharge report, which I believe is found at page 47, indicates that the immediate cause of death could not be ascertained. Does that accord with your recollection as to the feeling at the time of death?

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A. No, I do not believe so.

24

Q. Do I take it then what that

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2 represents was somebody's feeling but not necessarily  
3 yours?

4 A. It was certainly not mine and  
5 it was certainly not that of the cardiologist  
6 involved. We thought the death was due to pneumonia  
7 and heart failure.

8 Q. Are you able to assist as to  
9 how such a different conclusion could be reached by  
10 somebody in light of the feelings of yourself and  
11 the staff cardiologist?

12 A. Well, I think people put down  
13 what they think, I suppose, but I do not understand  
14 why that would be.

15 Q. But certainly if there was a  
16 feeling that the immediate cause of death could not  
17 be ascertained at the time of death given the  
18 references to digoxin toxicity that we have just  
19 referred to, there is a question of checking into  
20 those features, is there not?

21 A. I assume that is done  
22 automatically.

23 Q. What you are saying, though, is  
24 that that is done automatically by the physician in  
25 charge?

A. And the people with him.





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2 I do not know who wrote that report. Is there a name  
3 attached to that report? I do not have the record.

4 Q. I do not have a copy of it  
5 precisely in front of me.

6 MR. OLAH: Mr. Commissioner, that  
7 could be found at page 47. It is Dr. Daniel Halperin.

8 THE COMMISSIONER: Page 47?

9 MR. OLAH: Yes, sir, the signature is  
10 to be found half-way down page 47. It is the third  
11 page of the discharge report, sir.

12 THE WITNESS: And it is Dr. Halperin.  
13 Well, that may explain it because Dr. Halperin is a  
14 general pediatric resident not a cardiac fellow and  
15 not a cardiologist, and he probably wrote that note  
16 without perhaps the benefit of all the discussions  
17 that may have taken place.

18 MR. HUNT: Q. So the reference to  
19 digoxin, is it fair to say that the reference to  
20 digoxin toxicity is considered by you in light of the  
21 person who made the note?

22 A. Not necessarily only that, but  
23 that weighs in the judgment on the part of the  
24 cardiologist as to how much weight he will put on the  
25 matter.

Q. And how much investigation





1  
2 needs to be done?

3 A. Yes.

4 Q. And now, Real Gosselin died on  
5 December the 18th, again in the early morning hours.  
6 Now, you, in characterizing the terminal events, sir,  
7 indicated that there was a sudden onset of the  
8 terminal events and a very rapid and irreversible  
9 course was followed by them. I think you also  
10 indicated that one or more cardiologists expressed  
11 concerns about the suddenness of the deterioration but  
12 you yourself were not concerned because there was a  
severe coarctation?

13 A. Which had not responded to  
14 therapy.

15 Q. Correct, but is that a fair  
16 summary of what you have indicated?

17 A. Yes.

18 Q. Now then, your attention was  
19 drawn by Mr. Lamek to page 36 of the chart, which is  
20 Exhibit 72, which is Dr. Freedom's reporting letter  
21 to Dr. Miller in St. Boniface, Manitoba, dated  
22 December the 18th. In that letter, in the first  
paragraph on the second page, he says:

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2 "In summary then this patient had a  
3 severe thoracic coarctation of the  
4 aorta and I am really disturbed by  
5 this baby's demise just a few hours  
6 prior to surgery. I doubt that the  
7 demise can be explained purely on the  
8 basis of apnea secondary to the  
9 prostaglandin therapy and at this time  
10 I really don't have a good explanation  
11 for this baby's sudden deterioration  
12 and death.  
13 If microscopic examination adds anything  
14 more I will of course forward these  
15 results on to you as well."  
16  
17 Now, would you agree with me that as  
18 at the date that letter was written there is certainly  
19 some doubt about the cause of death?  
20  
21 A. As Dr. Freedom writes that  
22 letter, yes.  
23  
24 Q. And it would appear that some  
25 further examination was certainly contemplated if  
not actually underway by the reference to the  
microscopic examination that was to follow?  
A. Yes.  
Q. And is this also, Sir, not a





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2 case that falls clearly within the conditions that  
3 require reporting up to the coroner?

4 A. That would be the case if  
5 indeed Dr. Freedom was fully informed of the course  
6 of events at the time. He was not the cardiologist  
7 on duty at the time of that death. The Ward A  
8 cardiologist was Dr. Izukawa.

9 Q. Right.

10 A. And if he got that information  
11 through other sources there may be a difference of  
12 opinion. You would have to ask him that question I  
13 believe.

14 Q. You would agree with me it would  
15 appear on the face of it there is some doubt about  
16 that?

17 A. Just as the previous letter says,  
18 yes.

19 Q. All right. Now, the next baby  
20 I would like to turn to is Janice Estrella and we  
21 considered this case this morning with respect to the  
22 issue of whether or not it was reported in January.  
23 If we assume for the moment that it was reported at  
24 the time of death and then for whatever reason, perhaps  
25 reasons of the clinical condition and the background  
that were given to the coroner at the time it was





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2 rejected as a coroner's case, at a subsequent  
3 point in time information is available with respect  
4 to the digoxin levels?

5 A. Yes.

6 Q. That were found at the samples  
7 taken.

8 Now, are you aware as to when the  
9 information with respect to those levels first came  
10 to the attention of any of the cardiologists?

11 A. I'm not sure. I think that  
12 Dr. Freedom may have been the first person to learn  
13 that at an earlier stage.

14 Q. And I think his evidence with  
15 respect to that issue given at the preliminary  
16 inquiry in the Nelles matter, which is found in  
17 Volume 21 ---

18 THE COMMISSIONER: Is this the preliminary  
19 inquiry?

20 MR. HUNT: Yes, this is the preliminary  
21 inquiry proceedings, February 19th of 1982.

22 Q. Dr. Freedom indicates that he  
23 did order digoxin levels to be obtained for her.  
24 He spoke to Dr. Glen Taylor and then beginning about  
25 line 14 he is questioned by the Crown Attorney Mr.  
McGee. This is with reference to Dr. Taylor:





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"Did you ever ask him to draw blood  
and to obtain a digoxin reading for  
that baby following the baby's death?

A. I do not remember stating that  
to Dr. Taylor.

Q. All right. Did you ever receive  
a digoxin level for Baby Estrella that  
had been taken post mortem?

A. Yes I did. Several days or a  
week or two later, I can't remember the  
time frame but I was informed that a  
digoxin level had been returned with a  
very very high level.

Q. All right. Do you remember  
what that level was?

A. I believe it was in the seventies.

Q. The seventies, all right. Have  
you ever heard of digoxin levels that  
high before in children?

A. No.

Q. What did you do as a result of  
hearing that?

A. When I was informed that this  
level was seventy I said it must be a  
lab error, either a calculation error





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"or perhaps the way it was sampled  
and I suggested that they check with  
biochemistry who ran the sample.

Q. Did you ever hear back whether  
that was checked?

A. No. I commented to Doctor, I  
believe it was Dr. Taylor, that if there  
was a problem with this level to get  
back to me and I never heard."

Now, does that accord with your  
recollection that Dr. Freedom was aware some time  
either days or several weeks after the samples were  
taken or the request was made?

A. I think so.

Q. Now, even assuming that this  
case was not reported -- that this case was reported  
and the coroner said he didn't think it was an  
appropriate case to investigate at the time, when  
those levels came back, you would agree, I take it,  
that that is a startling level?

A. Yes.

Q. Is that not the sort of  
information that re-opens again the whole question  
of reporting it to the coroner?

A. Yes.

But no investigation was done!

When was that?



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3 Q. And would you agree that that  
4 is a level that requires an investigation?

5 A. Yes.

6 Q. If it was turned down initially,  
7 is there any reason why it was not re-reported at  
8 the time that information became available?

9 A. I know. I don't know why it  
10 wasn't. The only explanation that I have was that ---

11 MR. PERCIVAL: Mr. Commissioner, we  
12 didn't hear that answer, I'm sorry.

13 THE WITNESS: I don't know of any  
14 reason why it wouldn't be other than the information  
15 we later know about this sample.

16 THE COMMISSIONER: Other than what?

17 THE WITNESS: The information we know  
18 later about those samples. When that information came  
19 back to us, later, at a much later period, there  
20 was information that the samples had been contaminated  
21 the sample had been contaminated.

22 MR. HUNT: But surely that fact alone  
23 doesn't remove the need for any kind of an  
24 investigation into what brought about the sample in  
25 the first place - what brought about the level in  
the first place, I'm sorry.

A. Well, if it was contaminated





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2 then that reduces the value of that observation  
3 very much.

4 Q. It may well reduce it but that  
5 is the sort of thing that becomes apparent in an  
6 investigation into what caused the level.

7 A. Surely.

8 Q. Now, notwithstanding that  
9 level was reported in January, some time in January  
10 to Dr. Freedom, you first became aware of that in,  
11 I think you said the second week in March?

12 A. Yes.

13 Q. That was when you saw the final  
14 autopsy report?

15 A. Yes.

16 Q. And it was at that time or  
17 shortly after that time that it was first reported  
18 to the Coroner?

19 A. Yes, it was two days later I  
20 believe. It was the same day, the 18th.

21 Q. The same day that you received  
22 the information?

23 A. The same day -- oh, I'm sorry,  
24 I've got the wrong case.

25 Q. You may be thinking of Pacsai?

A. Yes, I am, I'm sorry.





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Q. It was reported to the coroner  
on March 20th, wasn't it?

A. The 20th, yes, that was a  
Friday.

Q. The day before the meeting?

A. And it was reported from the  
Pathology Department.

Q. Were you yourself aware that the  
Pathology Department was reporting it to the coroner?

A. No.

Q. When you became aware of that  
level in March you became concerned enough to request  
Dr. Freedom to look into it, did you not?

A. Yes.

Q. Again, is there any reason why  
at the time you became aware of it you didn't  
immediately report it to the coroner instead of  
conducting your own investigation?

A. No, because the post mortem  
report had said that the samples were contaminated.

Q. You agree with me that is  
certainly one of the factors and it may be a very  
important one that would have to be weighed by the  
coroner if he was conducting an investigation?

A. Yes.





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2 Q. Now, Jordan Hines died in the  
3 early morning hours on March 8th of 1981 and if I'm  
4 correct it was your view with respect to that death  
5 that nobody had expected Jordan Hines to die over-  
6 night at that particular time?

7 A. That is correct.

8 Q. And <sup>there</sup> it was clear concern as  
9 to the cause of death the following morning?

10 A. Yes.

11 Q. Dr. Rose was adamant that there  
12 be a postmortem examination?

13 A. Yes.

14 Q. And I take it it was felt that  
15 information obtained on a postmortem examination might  
16 assist in questions with respect to the cause of  
17 death?

18 A. Yes.

19 Q. A consent to do a postmortem  
20 examination was obtained and was in fact done and  
21 one was in fact done?

22 A. Yes, it was.

23 Q. And it appears that one of  
24 the conditions that was thought that might have  
25 contributed to death, if not was the cause of death  
was found not to be so by the pathologist?





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A. Eventually.

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Q. This is after the postmortem examination?

5

A. Yes.

6

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Q. Now, I suggest to you that this is a clear case where the requirement to report it to the coroner was fully established as of the morning of the death?

9

A. I think it fits that category.

10

10

11

Q. There was certainly doubt as to the cause of death?

12

A. Yes.

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Q. And what happened was that concern was expressed amongst the cardiologists that an investigation was commenced to determine what light could be thrown on the cause of death?

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A. Yes.

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Q. And is that consistent with the approach that I think you have said had been taken before, in terms of the Hospital, or the Department conducting its own investigation?

A. Is it consistent with the Department conducting its own investigation? Yes.

Q. In going ahead with the postmortem examination?

A. Yes.

Q. And prior to discussing the matter with the Coroner, if at all?

A. That is right.

Q. Now, Kevin Pacsai died at I believe 10:10 on the morning of March 12th, and you in discussing the terminal event indicated that at the time of death there was no good reason why the baby had died?

A. Yes.

Q. And at that time this case was in fact reported to the Coroner very shortly after death took place?

A. That is right.

Q. As far as you know, what was the reason that this case was reported to the Coroner at the time?





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3 A. I am not sure of the exact  
4 cause, but I think that we discussed this case,  
5 Dr. Fowler and I and decided that the matter should  
6 be reported to the Coroner. I think we were uncertain  
7 of the cause, and it was also a factor of the father's  
8 reaction to the death that concerned us.

9  
10 Q. So to broadly characterize  
11 it, two concerns, one was the father's reaction to  
12 the death.

13 A. Yes.

14 Q. And secondly, the concern  
15 re the cause of death.

16 A. I believe so.

17 Q. Now, when the levels, the  
18 digoxin levels came back from the lab with respect  
19 to Kevin Pacsai, I believe that was on March 14th  
20 and March 16th?

21 A. We didn't receive any, I  
22 didn't receive any level until the 18th.

23 Q. The levels as well were  
24 reported to the Coroner shortly after they became  
25 available.

A. I know the level of the 18th  
was reported to the Coroner.

Q. I am not sure it was a level

Not  
Fowler's w!





1  
2 reported on the 18th, you heard about it on the 18th,  
3 that is your recollection?

4 A. Yes, and the Coroner was  
5 called again on that day by us, by Dr. Fowler  
6 actually as far as I am aware.

7 Q. At the time the Coroner didn't  
8 have the information with respect to the level found  
9 in Janice Estrella, is that correct?

10 A. I don't think so.

11 Q. Because that level was first  
12 communicated by Dr. Mansar on the 20th.

13 A. On the Friday, yes.

14 Q. By the date that you received  
15 the information about Kevin Pacsai's level, did you  
16 have the information about Janice Estrella?

17 A. Yes, we did.

18 Q. Is there any reason why you,  
19 or one of the other cardiologist didn't report the  
20 Estrella level to the Coroner prior to March the 20th  
21 when the pathologist did?

22 A. No. I presume for the same  
23 reason that the pathologist didn't report it in  
24 February?

25 Q. You presume, I am sorry I  
missed the last part.

EE3

Not Fowler's  
recollection!





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A. For the same reason that the pathologist didn't perhaps report it in February when they had Estrella's level in February.

Q. That was because of some question of contamination.

A. I presume so. Certainly we had sort of put that away.

Q. The Coroner now is in possession of the two levels for the first time, on March 20th.

A. Yes, sir.

Q. Once he is made aware of it, I take it the first thing that happens is a meeting is called for Saturday the 21st.

A. I think that must have been the sequence.

Q. And that is immediately upon him being made aware of the two levels?

A. I don't know what the time relationship was, I only know a meeting was called, that is all I know.

Q. You didn't become aware of it until some time on Friday, March the 20th, and on Saturday, March the 21st you were I believe at a meeting in his office in the afternoon?





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A. Right.

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Q. The purpose of that meeting

4

was for him to find out information about the

5

Estrella level and the Pacsai level?

6

A. I think that was so, I am

7

not sure it was levels they were after. It was what  
is going on.

8

Q. So the Coroner once he had

9

the two levels wanted to know what was going on?

10

A. Yes.

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THE COMMISSIONER: Would this be

12

a convenient time?

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MR. HUNT: Yes.

14

THE COMMISSIONER: We will take

15

15 minutes then.

16

---Short recess.

(2) jc

17

---Upon resuming.

(2)

THE COMMISSIONER: Yes, Mr. Hunt.

18

MR. HUNT: Thank you, Mr. Commissioner.

19

Q. Doctor, the next case I would

20

like to turn to is that of Allana Miller. Now, just

21

so that I have the sequence of events straight in my

22

mind: by Friday, March the 20th, not only do you have

23

the results of the levels in Pacsai and Estrella, the

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coroner has the results of the levels of Pacsai and

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EE.6

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Estrella, and the coroner has called a meeting in his office for Saturday afternoon, March the 21st at 2 o'clock.

A. Yes.

Q. And then you come into your office on Saturday morning to work and you were at some point during the morning informed of the death overnight of Allana Miller?

A. Yes.

Q. And I take it that was before you went to the meeting at the Coroner's office?

A. Yes. I think Dr. Fowler was the cardiologist on duty for the weekend and he was upstairs I think getting the information on the heart catheterization on Cook, which was being done that morning. I think that he had tried to contact me at home and found that I was in my office.

Q. He had tried to contact you specifically about the Miller death?

A. About the meeting I think.

Q. Oh, about the meeting?

A. Yes, and then I think I was told presumably about the death at the same time.

Q. You were not aware then of the meeting for that afternoon until you got to the office on Saturday?





EE.7

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A. That is correct.

3

Q. Now Allana Miller died in the

4

early morning hours of that Saturday. Is it fair for

5

me to say that there was certainly concern about the

6

role that digoxin might have played in her death, at

7

the time of her death?

8

A. At the time of her death?

9

Q. Yes.

10

A. Yes, I think there probably was.

I wasn't there at the time of her death.

11

Q. No, I am not suggesting that you

12

were. There were levels ordered to be taken ---

13

A. I think it was in relation to

14

the concerns and the other information that you have

just discussed.

15

Q. I think the chart itself

16

reflected that at 2:30 a.m., which was just very

17

shortly before the terminal events, there was a hold

18

digoxin order placed with respect to this baby. I

19

think you agreed that that order may have been placed

20

at that time because the doctors suspected that

21

digoxin was related to the vomiting and bradycardia

that was beginning to be apparent?

22

A. I can't see in my notes about

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that, but I think I remember that there was an issue

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of the irregularity which was simply a function of

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the pacemaker situation in the heart, but there were additional symptoms at that time.

Q Now, by the Saturday morning, knowing you were going to a meeting with respect to Pacsai and Estrella, and you received news about the death overnight, where there is an obvious concern about the role that digoxin may have played to the extend that there are notes on the chart re the holding of it at a critical time, and also I take it you were aware of certain tests that had been ordered?

A Yes.

Q To determine digoxin levels?

A Yes.

Q I think you indicated that going into that meeting, Saturday afternoon, you were at the least very concerned about the Miller situation at that time you didn't know what the levels were?

A I think that is true.

Q And then there is a meeting that begins at approximately 2 o'clock in the Coroner's office, at which time you are present, Dr. Fowler is present, Dr. Bennett, I think the Deputy Chief Coroner for the Province, and Dr. Teperman, the Regional Coroner. In addition I think there was Dr. Carver?





EE.9

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A. Yes. Miss Lund.

Q. Miss Lund?

A. Yes.

Q. And Sergeant Press, and Sergeant Warr and Mr. Murray.

Now you indicated that you couldn't remember whether or not the situation regarding Allana Miller was discussed at that meeting?

A. I can't remember the details of what was discussed at that meeting. Although of course I know what it was all about. I mean, we were there for one purpose I would have thought.

Q. Well, if I suggest to you that the Miller case was not reported to the coroner until Saturday evening when the levels, the digoxin levels had become known, would that be inconsistent with anything you can recall?

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A. I would have thought that that would have been something that must have come up in the conversation at that meeting, but I am not sure; I do not remember.

Q. Certainly, I suppose next to Pacsai and Estrella, it had to be a matter that was near the top of the concerns that you had going into that meeting?

A. Oh yes, absolutely.

Q. Well, if I am correct that the matter was not reported to the coroner until the evening of Saturday, March the 21st, would that not suggest that what really occurred was that the Hospital was conducting its own investigation into Allana Miller's death?

A. If that is really what happened.

Q. And certainly, if that is what happened, it would seem that an opportunity to inform the coroner in the most direct sense was missed Saturday afternoon?

A. If that is true, yes. I am surprised to hear that suggestion.

Q. Well, is there anything that you are aware of that does not agree with that statement?





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A. Well, I am not sure. I was under the impression that this death had been notified to the coroner and that the only thing that was not notified to the coroner was the value of the -- or that the value had not returned from the Biochemistry Department until 8 o'clock at night, and then he was called at 8 o'clock. So you know, I do not know. Dr. Fowler is probably the person who can clarify that because he was the physician on call and he was the one who must have communicated with the coroner.

Q. If that was a matter that was discussed in that meeting, is that not something that everybody is likely to remember?

A. Well, I would think so, but you know, I am astonished that I cannot remember all the things that went on in that meeting even though I was obviously very concerned about the case.

Q. Would you agree with me that whenever the coroner was notified, it was after the Hospital had undertaken its investigation at least insofar as the post mortem was concerned?

MR. ORTVED: Well, that is not his evidence. His evidence was that his understanding was it was reported save and except the level, which was something that was being investigated after.





Rowe, cr.ex.  
(Hunt)

1  
2 MR. HUNT: Q. Is it your understanding  
3 that Miller was reported to the coroner immediately  
4 upon Miller's death?

5 A. I thought that had been done,  
6 yes.

7 Q. At what time, do you know?

8 A. I do not know what time, but  
9 I thought that had been done by Dr. Fowler.

10 Q. All right. Then it is your  
11 understanding, although you have no precise recollection  
12 of it, that by the time you went into the meeting with  
13 the coroner, the coroner had taken charge of that  
14 investigation?

15 A. Well, I do not know. I presume  
16 that that should have been the case.

17 Q. And that is because of the  
18 circumstances that were prevailing at the time of  
19 the death?

20 A. Yes.

21 Q. Insofar as Allana Miller is  
22 concerned, you would agree with me that this was a  
23 case that as at the time of death was one that was  
24 properly investigated by the coroner, was properly  
25 one to be investigated by the coroner?

A. Yes.





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Q. Now, sir, insofar as Justin Cook is concerned, he died at 4:56 on the morning of March 22nd, and are you aware as to the fact that Dr. Fowler did report that to the coroner at 5:30 in the morning?

A. I knew -- at least I understood he had reported it. I do not know what hour he reported it.

Q. You are aware that the officers who were at that time about to undertake a coroner's investigation were made aware of that death prior to arriving at the hospital on Sunday morning, March the 22nd?

A. I am not sure; I do not know whether they were or not.

Q. You were not aware as to whether or not Dr. Teperman, on being informed of that, arranged for the officers to meet with Dr. Fowler first thing in connection with that death?

A. I found that out on Sunday morning I think. I cannot remember again the specifics of those commentaries because I was called at home, I guess, and came in.

MR. HUNT: Those are all the questions I have, Mr. Commissioner.



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THE COMMISSIONER: Thank you, Mr.

Hunt. Mr. Percival?

CROSS-EXAMINATION BY MR. PERCIVAL:

Q. Doctor, can I take you back to March of 1981, and you have talked about a number of different syringes that were available for use in the Hospital for Sick Children. You have talked in terms of a 60 millilitre syringe. Was that available on Wards 4A and 4B in March of 1981?

A. I do not know.

Q. You have talked in terms of a 20 millilitre and 30 millilitre syringe which have not been marked as exhibits. Were they available in Wards 4A and 4B in March of 1981?

THE COMMISSIONER: I thought we did -- oh yes, that is correct, we did not have those.

THE WITNESS: I am not sure.

MR. PERCIVAL: Q. You have talked in terms of was it a 6 millilitre syringe?

A. I cannot remember whether it was 6 or 5, 6 probably.

Q. Was that commonly available on Wards 4A and 4B in March of 1981?

A. I am not sure.

Q. Are you sure that all of these





1  
2 syringes that you have talked about were available  
3 in the Hospital?

4 A. I do not know whether those  
5 specific brands or anything else were available, but  
6 I am sure that syringes of those capacities were  
7 available in the Hospital.

8 Q. All right. Was a syringe of  
9 a 12 millilitre capacity available in March of 1981?

10 A. I do not know.

11 Q. So do I take it that as a result  
12 of the requests for the syringes, it really is what  
13 syringes are presently available in the Hospital  
14 for Sick Children and that is what you produced?

15 A. Yes.

16 Q. I understand. One of the things  
17 that has been brought out by Mr. Strathy and I  
18 perhaps would like to address my mind to it has been  
19 the ampules, the elixir and the pills, the type of  
20 digoxin that was available in March of 1981, and we  
21 talked in terms of the use of the syringe. Can I  
22 assume that most of these babies, in fact all 36 of the  
23 babies with which we are concerned, had an IV in place  
24 at the time of their terminal events?

25 A. I cannot answer that.

Q. Well, the ones for which digoxin





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was being given, would they have IVs in place?

A. Some of them would.

Q. Are you able to see from any of the records that have been filed whether or not IVs were in place or not in place?

A. Yes, you can tell that from the record.

Q. Well, particularly with respect to Estrella, Pacsai, Cook and Miller, are you able to assist us in relation to whether or not those babies had intravenous lines in place at the time the terminal events occurred?

A. That information would be in their hospital records. I cannot remember that off-hand.

Q. Well, would you be good enough perhaps overnight to end up looking at those and assist me in this regard tomorrow?

A. All 36?

Q. No, the last four I just mentioned.

A. Could I have those again, please?

Q. Estrella, Pacsai, Miller and Cook.

A. Sure.





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Q. And would the place that you are going to look for that in the medical records be in relation to the medication, a portion of the chart or record to indicate whether medication was being given intravenously?

A. Yes.

Q. Or would you be looking somewhere else?

A. No, I would be looking there.

Q. Would you look then overnight?

A. I will.

Q. Let me take you to the situation where an IV line is in a baby, without mentioning any particular identity. Can there be more than one intravenous line into a baby at one time?

A. That is possible.

Q. And would you know from the medical records that we have filed with the Commission whether or not one or more intravenous lines were into that baby at the time the terminal events occurred?

A. No, I would not.

Q. Let us talk about the intravenous. Some of us have been in hospitals and none of us know the technical terms. I presume you can





1  
2 assist us in this regard.

3 There is usually a post beside the  
4 bed and is there a post in fact beside the bed or  
5 whatever is containing the baby at the Hospital for  
6 Sick Children?

7 A. No, there is a stand.

8 Q. A stand. And at the top end  
9 of the stand there is a bag of something?

10 A. Yes.

11 Q. And it usually contains what,  
12 about a millilitre -- I am sorry, a litre of some  
13 liquid?

14 A. I do not know precisely what  
15 amount.

16 Q. Well, approximately what sizes  
17 are those bags of liquid?

18 A. You know, I do not hang the bags  
19 or have much to do with bags. You know, if you want  
20 that sort of information you really should ask the  
21 nurses.

22 Q. Well, I just want to know how  
23 an IV runs. I am not talking about any of these  
24 particular 36. I want to know how it runs. Is the  
25 bag usually containing a liquid such as a saline  
solution or a glucose and water solution?





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A. Yes, a glucose solution usually.

Q. Then below that bag there is what I am advised is a line going into what is called the buretrol, b-u-r-e-t-r-o-l; is that correct?

A. I am not familiar with the details of these things.

Q. Well, Doctor, how does it go from the bag of liquid into the baby?

A. It drips through a container of some sort.

Q. You are not familiar with that terminology buretrol?

A. Well, you know, I grew up a long time ago and they have changed things.

Q. Well, it drips through something and is this another container?

A. Yes.

Q. And the dripping really gives the -- controls the rate of infusion of the liquid into the baby's body; is that correct?

A. Yes. Well, I am not sure that controls it. Yes, I think it does.

Q. All right. And quite apart from the natural flow of gravity infusing into a baby's body, there is also from time to time in babies





1  
2 a type of pump that can be used; are  
3 you familiar with that?

4 A. Yes.

5 Q. Again, are you able to assist  
6 us from the records whether or not pumps were  
7 utilized in intravenous so far as any of these 36  
8 babies are concerned?

9 A. I do not know. They may have  
10 been in the intensive care unit but I am not sure  
11 while they are on the ward.

12 Q. Was that commonly seen in  
13 Wards 4A and 4B?

14 A. I cannot answer that.

15 Q. All right. Now, below this  
16 dripping container, if I can use that, there is a  
17 line going down to the baby; is that correct?

18 A. Yes.

19 Q. And in that line, there are  
20 a number of ports, are there not, for the purpose  
21 of injecting some form of medication into the liquid  
22 dripping into the baby's veins or arteries?

23 A. I think there are, but again,  
24 I am not familiar with all the details of that because  
25 I do not do that sort of thing.

Q. Well, if you have an IV going





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into a baby and you are to give some medication  
intravenously, do you start a new IV or do you inject  
it into an IV that is already running?

A. Into one that is already  
running.

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Q. All right. And the method of injection has to be surely through some port of entry?

A. Yes.

Q. In the line?

A. Yes.

Q. All right. Now, let me talk about the syringes that we have had marked as exhibits. If someone was going to give an injection of digoxin, whether from an ampoule, from an ampoule form, the ampoule is broken, the syringe and a needle is then used to take the digoxin from the ampoule into the syringe, is that correct?

A. Yes.

Q. Presuming the digoxin is to be administered intravenously, then is the syringe used to inject through one of these ports into the line that is already passing into the baby?

A. Yes, I believe that is so.

Q. All right. For instance, suppose we have a 12 millilitre syringe full of 12 millilitres of digoxin, if it is filled with digoxin, can it be injected into the line fairly quickly, slowly; can you assist me in this regard?

A. I don't know how long it would take to get in, but I don't think you would get 12 ccs





GG2

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in in a big hurry.

3

Q. Well, what are we talking about,

4

30 seconds, 60 seconds?

5

A. I don't know.

6

Q. All right.

7

A. I have no experience with that

8

sort of thing.

9

Q. I understand, Doctor, but I

10

just wanted to know that that would be the method of  
giving digoxin intravenously?

11

A. Yes.

12

Q. That would be the manner in

13

which it would go?

14

A. If you gave a regular dose in

15

the usual amount it would go in in a cc or something  
like that.

16

Q. It was put to you by Mr. Strathy

17

I believe yesterday or the day before -- no, I think

18

it was yesterday -- that there was a possibility that

19

in the course of resuscitation that digoxin ampoules

20

might have been mistakenly used instead of adrenaline  
ampoules?

21

A. Yes, it was suggested.

22

Q. Yes. You're not sure; while

23

it's a possibility there might have been 36 different

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3 drug overdoses in relation to 36 baby deaths if all  
4 of them had symptomatology consistant with digoxin  
5 toxicity?

6 A. Yes.

7 Q. Surely that wouldn't happen in  
8 the Hospital for Sick Children?

9 A. 36 deaths?

10 Q. Yes, caused by overdoses?

11 A. I would be very surprised.

12 Q. Yes. So, if it is a possibility  
13 it is a very remote possibility?

14 A. For 36 deaths?

15 Q. No, for an interchange of  
16 digoxin for adrenaline.

17 A. Yes, I think it is.

18 Q. You have mentioned in the course  
19 of your cross-examination that digoxin might be  
20 utilized in a resuscitation, I think you gave one  
21 possibility I believe to someone yesterday, or perhaps  
22 this morning, is that a particular situation that you  
23 described a very, very remote type of a situation?

24 A. Yes, it is.

25 Q. Something that you would not be  
likely to expect to have happen on a ward such as  
wards 4A and 4B?





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A. That is correct.

Q. And because it is not likely to happen, you are not likely to have digoxin on the crash-carts which are located in wards 4A and 4B?

A. Yes.

Q. All right. You have crash-carts, and we talked about them, you have crash-carts in various parts of the hospital, is that correct?

A. Yes.

Q. For resuscitation. So, you do not want to have to run around the hospital with one crash-cart servicing a number of different wards?

A. No.

Q. So, in wards 4A and 4B there was a crash-cart available in case a Code 25 was called?

A. There were two.

Q. Two of them, one in 4A and one in 4B?

A. Yes.

Q. Supposedly fully equipped with all the necessary medication for the purposes of resuscitation?

A. Yes.

Q. Now, you might have digoxin,





GG5

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I suggest to you, in one place in the hospital and  
a crash-cart and that might be in the emergency ward?

3

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A. Yes, that would be a good  
suggestion.

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Q. No, well, no, but does that  
happen?

7

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A. I don't know.

9

Q. All right. So, you can't  
assist me in that regard?

10

A. No.

11

Q. All right. Following the

12

death of Baby Cook, you have indicated that the

13

doctors were checking for, and I do not speak this  
name, is it parenteral?

14

A. Parenteral, that's correct.

15

Q. Parenteral on the crash-cart?

16

A. Yes.

17

Q. Do you recall giving that

18

evidence at page 3272?

19

A. Yes.

20

Q. After that you checked the

21

crash-carts?

22

A. I didn't but a resident did,

the chief resident did.

23

Q. Your understanding is there was

24

25





GG6

1  
2 no digoxin found?

3 A. That's my understanding.

4 Q. All right. Parenteral digoxin  
5 is the only type of digoxin that can be injected?

6 A. Yes.

7 Q. All right. Following the death  
8 of Baby Cook, that you were checking on the crash-  
9 carts for digoxin of any injectable form was because it  
10 was your view and that of your staff at that time  
11 that the likely method of administration was through  
12 the IV, or through the use of syringes. Is that  
correct?

13 A. Yes, that was to remove it  
14 from that possibility.

15 Q. Well, to remove it from the  
16 possibility that it was on the crash-carts?

17 A. Yes.

18 Q. But do I take it that that was  
19 the most likely means of injection of the digoxin  
20 following Baby Cook's death that you and your staff  
21 were contemplating.

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GG THE COMMISSIONER: Excuse me, just a moment. What you said was through the IV or through a syringe?

MR. PERCIVAL: Through a syringe, intramuscular.

THE COMMISSIONER: Could it not be both?

MR. PERCIVAL: Or both, yes, quite, Mr. Commissioner.

Q. Was it not thought after the death of Baby Justin Cook by you and your staff that the most likely means of administration of the digoxin was either by a syringe or through an IV?

A. Yes, it was.

Q. All right.

THE COMMISSIONER: And if it goes, if I understand properly, if it goes through the IV it would be put in through one of these ports by syringe.

THE WITNESS: Yes, yes it would.

MR. PERCIVAL: Q. Now, I have a couple of matters that I want to deal with, and perhaps just to clarify some things, we talked in terms, or you talked in terms, on Volume 10, pages 1703 to 1706 and laterly in Volume 20 at pages 3539

And we know what he thinks of general  
paed. residents!



2GG2  
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3 about doctors on duty after midnight. I'm not going  
4 to direct you to those specific things but you talked  
5 in terms of what doctors are there and what doctors  
6 may or may not be. After midnight and up until about  
7 4 or 5 o'clock when your dedicated cardiologists might  
8 return to the Hospital, is there a doctor physically  
9 on Ward 4A and 4B in March of 1981?

10 A. Not actually on the ward,  
11 he is in a bed near the ward.

12 Q. All right. And these are  
13 cardiology residents, are they not?

14 A. These are general pediatric  
15 residents.

16 Q. General pediatric residents.  
17 And they are working a 24-hour shift at that point?

18 A. I'm not sure.

19 Q. All right. The distinction  
20 between, and I suppose this is why you call a Code 23.  
21 A Code 23 is for the purposes of calling a doctor to  
22 give assistance?

23 A. Yes, it is.

24 Q. All right. And if on 4A and  
25 4B in March of 1981, if the pediatric resident was  
in his bed, as he might be, a Code 23 is called and  
then he is alerted and he comes to the ward?

A. Yes.





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Q And that code would of course not be necessary at all if there was a doctor physically always on 4A and 4B after midnight?

A You mean walking around?

Q That's right.

A Yes.

Q Yes, thank you.

There is another matter involving procedure that I perhaps would like to clarify. There is, in the course of these 36 baby records, in some cases at least, doctor's orders for the administration of digoxin, and I'm trying to remember, was it at 9 a.m. in the morning and then if it was given twice a day, what is the other time, Doctor?

A 2100 hours.

Q That would be at 9 o'clock?

A Yes.

Q 9 p.m.?

A I think so.

Q Yes, I think you are right in that.

If you have a doctor's orders to that effect and then a subsequent doctor's orders to the effect that a serum level digoxin test would be ordered for 9 a.m., does that modify or change the





GG3.2

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2 time of administration of digoxin?

3 A. Yes, it does.

4 Q. All right. But that is why we  
5 see in some of the charts, instead of the digoxin  
6 being given at 9 a.m., if a serum level had been  
7 requested at that time the digoxin is given earlier  
8 at 5 a.m. or 5:30 a.m., is that correct?

9 A. Yes, that was in effect at that  
10 time.

11 Q. I understand. The reason for  
12 that is that you don't want to take a digoxin serum  
13 level test 15 minutes after you have given digoxin?

14 A. No.

15 Q. You want to wait for the 3 or  
16 3-1/2 or 4 hours after the last?

17 A. You want to wait for about 8 hours  
18 but at that time it was only 4.

19 Q. All right, I understand. Now,  
20 one thing perhaps, and I'm going to be selective,  
21 Mr. Commissioner, I want to hit one other thing. I  
22 know you have a meeting at 5:30 and I would like to  
23 end with this today if it is satisfactory and it is  
24 something that concerned me about your corss-  
25 examination by Mr. Hunt.

I am talking in terms of March 21st,





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Saturday, March 21st, when you and a number of other people were going to the Chief Coroner's meeting, 2 o'clock in the afternoon, with two police officers. Do you remember that?

A. Yes.

Q. Mr. Hunt suggested to you that you knew about Baby Miller's death but you were there at that meeting specifically to discuss Baby Estrella and Baby Pacsai?

A. Yes.

Q. All right. And in your evidence already you have seemed to indicate that you don't know, or don't remember whether the death of Baby Miller was in fact discussed at that meeting with the coroner and the police officers?

A. Yes.

Q. And yet you say you would be surprised if you didn't?

A. Yes.

Q. The fact that you would be surprised would be - is that it followed the same pattern, didn't it?

A. Yes.

Q. If both of the police officers that were present at that meeting in the Coroner's





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office in the afternoon of Saturday, March 21st,  
categorically deny that either you or any of your  
other physicians at the Hospital in any way, shape  
or form mentioned the death of Allana Miller, are you  
in a position to disagree?

A. No.

Q. That would be terribly surprising,  
wouldn't it?

A. Yes.

Q. If not shocking?

A. Yes.

Q. Because had you told the officers  
maybe something else could have been done, might have  
even saved Baby Cook that night?

A. Yes. I'm not sure when I first  
learned about the ---

Q. I understand that.

A. Yes.

Q. But if they say you didn't.

A. Or that Dr. Fowler didn't?

Q. Nobody did.

A. I see. Well that's ---

Q. Is bad, eh?

A. Yes.

MR. PERCIVAL: May I end on that?





GG3.5

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THE COMMISSIONER: Yes.

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MR. PERCIVAL: Thank you.

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THE COMMISSIONER: Well then, I wonder,

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before ending, if you could give us some indication  
of how long you think you would be.

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MR. PERCIVAL: I would think until  
12 o'clock, ten to twelve.

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THE COMMISSIONER: Miss Kately, are  
you next?

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MS. KATELY: I believe we are next,  
yes.

12

THE COMMISSIONER: Yes.

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MS. KATELY: In an hour to two hours.  
We will be finished at the lunch break and a little  
bit in the afternoon, sir.

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16

THE COMMISSIONER: All right. Now, who  
is here for the Nurses Assistants?

17

MS. COHEN: I am, sir.

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THE COMMISSIONER: Yes.

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MS. COHEN: I don't expect we will have  
any questions.

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THE COMMISSIONER: All right. Well,  
who comes after that?

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MS. JACKMAN: Mr. Commissioner, I  
believe I follow the Nursing Assistants.

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THE COMMISSIONER: Pardon?

MS. JACKMAN: I believe I follow the  
Nursing Assistants.

THE COMMISSIONER: Yes, all right. And  
how long do you think you will be?

MS. JACKMAN: I don't expect that I  
will be any longer than about an hour.

THE COMMISSIONER: Yes, all right.  
And Mr. Olah, are you after that?

MR. OLAH: No, I think Mr. Buhr is.

THE COMMISSIONER: No, actually,  
Mr. Buhr I think you come after the Nursing Assistants,  
don't you?

MR. BUHR: I was quite prepared to be  
forgotten about completely, Mr. Commissioner.

THE COMMISSIONER: All right.

MR. BUHR: But I don't anticipate  
having any questions or, at the most, a few minutes.

THE COMMISSIONER: All right. Well, we  
will probably finish tomorrow. Mr. Manning, I see you  
are here. Now, you have got some problems I understand.

MR. MANNING: That's correct, Mr.  
Commissioner. Hopefully I will be able to speak to  
my friends after break today and hope to proceed and  
maybe follow Mr. Percival.





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THE COMMISSIONER: Well, all right,  
see if that can be arranged. Have you any objection  
to that, Ms. Kately?

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MS. KATELY: No, I understand it has  
been previously discussed and I don't have any  
problems with that.

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THE COMMISSIONER: Why don't we then  
take Mr. Manning after Mr. Percival is finished and  
then other than that does anyone else feel hurt about  
being ...

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MR. OLAH: Well, Mr. Commissioner,  
perhaps we could ask Mr. Manning how long he thinks  
he will be?

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THE COMMISSIONER: Yes, we can ask him  
that too.

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MR. MANNING: Probably two hours.

THE COMMISSIONER: Two hours. That  
looks like tomorrow.

MR. OLAH: May I safely assume that I  
will not be required then to cross-examine tomorrow,  
Mr. Commissioner?

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THE COMMISSIONER: You want a promise,  
is that it?

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MR. OLAH: Just an undertaking.

THE COMMISSIONER: I think all





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assumptions have to be made by the assumer.

MR. TOBIAS: I spoke with Mr. Olah yesterday, he asked me whether I would have any objections to his cross-examining after myself and counsel for the other parents.

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I don't presume to speak for counsel  
for the other parents but I certainly have no  
objection to Mr. Olah cross-examining last.

MR. OLAH: There is no question that  
is the purpose of the exercise.

THE COMMISSIONER: Once again, that  
is something to sort out. Mr. Manning, you have  
already been dealt with. So until tomorrow morning  
at 10 a.m.

--- Whereupon the Hearing was adjourned until  
Thursday, August 25th, 1983, at the hour of  
10:00 a.m.





